Legislative Assembly of the Northern Territory

Legal and Constitutional Affairs Committee

Voluntary Assisted Dying in the Northern Territory

Final Report
September 2025

Voluntary Assisted Dying in the Northern Territory – Final Report

The Report contains information that may be distressing as it relates to death and dying. If you need support, you can contact Lifeline at 13 11 14 for crisis support or Griefline on 1300 845 745. Aboriginal and Torres Strait Islander people can also contact 13YARN on 13 92 76 for crisis support.

Legislative Assembly of the Northern Territory

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Chair's preface

This report represents the best efforts of the Legal and Constitutional Affairs Committee to address the Terms of Reference provided on 14 May 2025 to inquire into Voluntary Assisted Dying (VAD) in the Northern Territory. The VAD Inquiry was challenging on innumerate fronts, in terms of subject matter, scope, and timeframe for delivery. It is a credit to all involved that the work presented herein is of significant quality.

It is seldom the case that reports such as this are able to capture and represent all perspectives and materials gathered and submitted. For that reason, we encourage interested parties to engage with source materials in conjunction with this report, to further understand the breadth of the data collected and positions presented.

Notwithstanding the aforementioned, I am pleased to present this Final Report on VAD in the Northern Territory to the Legislative Assembly, and public at large, as testament to a collective commitment to progress resolution of VAD for Territorians. In doing so, I express my gratitude to my fellow Committee Members, and the Committee Secretariat, for their respective efforts towards completing this Inquiry. Finally, I thank again the many hundreds of Territorians who have contributed to this process, and whose contributions have undoubtedly enriched our understanding of what is involved in 'finishing up well'.

Dr Tanzil Rahman MLA

Chair

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Acronyms and abbreviations

2024 Expert Panel Report	Report into Voluntary Assisted Dying in the Northern Territory
ACCHO	Aboriginal Community Controlled Health Organisation
ACCHS	Aboriginal Community Controlled Health Service
ACT	Australian Capital Territory
AHPRA	Australian Health Practitioner Regulation Agency
AIS	Aboriginal Interpreter Service
ALA	Australian Lawyers Alliance
ALO	Aboriginal Liaison Officer
AMA NT	Australian Medical Association Northern Territory
AMSANT	Aboriginal Medical Services Alliance Northern Territory
APS	Australian Psychological Society
ARRCS	Australian Regional & Remote Community Services
Auslan	Australian Sign Language
CDP	Continuing Professional Development
CEO	Chief Executive Officer
CHO	Chief Health Officer
CHSP	Commonwealth Home Support Programme
CME	Continuing Medical Education
CMO	Chief Medical Officer
DNR	Do Not Resuscitate
Expert Panel	The Voluntary Assisted Dying Independent Expert Panel
GP	General Practitioner
ICO	Institutional Conscientious Objection
IMS	Information Management System
IT	Information Technology
MHACA	Mental Health Association of Central Australia
NAATI	National Accreditation Authority for Translators and Interpreters
NSW	New South Wales
NT	Northern Territory
NTCAT	Northern Territory Civil and Administrative Tribunal
NZ	New Zealand
PGNT	Pharmacy Guild of Australia Northern Territory Branch
PSA	Pharmaceutical Society of Australia
QLD	Queensland
QUT	Queensland University of Technology
QVAD	Queensland Voluntary Assisted Dying

ROTI Act	*Rights of the Terminally Ill Act 1995* (NT)
RUM Program	Return of Unwanted Medicines Program
SA	South Australia
SPA	Speech Pathology Australia
TAS	Tasmania
The Committee	The Legal and Constitutional Affairs Committee
VAD	Voluntary Assisted Dying
VADSA	Voluntary Assisted Dying South Australia
VIC	Victoria
WA	Western Australia

Glossary

Term	Definition
2024 Report	Report into Voluntary Assisted Dying in the Northern Territory: Final Report 2024 by the Voluntary Assisted Dying Independent Expert Advisory Panel.
2025 Report	Report of Legal and Constitutional Affairs Committee: Final Report 2025.
Administration	The act of administering the substance used for VAD.
Administration Decision	A clear and unambiguous decision made by the person accessing VAD, in consultation with and on the advice of their Coordinating Practitioner, as to whether the person will self-administer the VAD substance, or have the substance administered to them by an Administering Practitioner.
Administering Practitioner	An Authorised VAD Practitioner who administers the VAD substance to an eligible person who has made a Practitioner Administration Decision in the presence of a witness.
Advance Personal Plan	The document in which a person can nominate their preferred healthcare decision-maker.
Authorised VAD Practitioner	A practitioner who meets the eligibility requirements to be a participating health practitioner in the VAD process including being approved by the CEO.
Centralised Service	As defined in the 2024 Report: 'A stand-alone single service for the delivery of VAD.
CEO	Where a recommendation or the drafting instruction mentions CEO, this means Chief Executive Officer of the NT Department of Health.
Coercion	The act or power of compelling someone into an action.
Conscientious objection	The position of a person who declines to participate in a lawful process, such as VAD, due to their personal beliefs, values, or moral concerns.
Coordinating Practitioner	An Authorised VAD Practitioner who accepts a person's First Request.
Consulting Practitioner	An Authorised VAD Practitioner who accepts a referral to conduct a Second Assessment for the person.

Contact Person	A role defined in VAD legislation. A Contact Person has responsibilities for the storage and disposal of the VAD Substance and reporting the death of the person, whether or not the death was as a result of the administration of the VAD Substance or another cause.
Cultural safety	As defined in the National Agreement on Closing the Gap: 'Cultural safety is met through actions from the majority position which recognise, respect, and nurture the unique cultural identity of Aboriginal and Torres Strait Islander people. Only the Aboriginal and Torres Strait Islander person who is recipient of a service or action can determine whether [the service or action] is culturally safe.'[1]
Decentralised model of VAD service delivery	In contrast to a centralised service model (a stand-alone service), a decentralised model of VAD service delivery involves VAD provision through the public and private sectors (including general practitioners).
Decision-making capacity	A person's capability to understand and make decisions about VAD.
Drafting instructions	QUT's drafting instructions that give effect to the policy positions of the Committee as included in the 2025 Report.
End-of-life care	Care provided to a patient during the last stages of life.
Euthanasia	The word euthanasia is derived from the Greek word of euthana-tos meaning 'easy death'. Generally it is used to describe the process of intentionally terminating a person's life to reduce their pain and suffering
Family Member	The person's spouse, parent, grandparent, sibling, child or grandchild or a person who, under Aboriginal tradition or Torres Strait Island custom, is regarded as family.
First Assessment	An Assessment conducted by the Coordinating Practitioner to assess whether the person is eligible for access to VAD by determining whether they meet all of the eligibility criteria.
First Request	A clear and unambiguous explicit request, by the person, for assistance to die. It is made to a medical practitioner by the person themselves.
Formal Request	A second request for access to VAD that a person makes after being assessed as eligible by the Coordinating Practitioner and the Consulting Practitioner. It must be

[1] Closing the Gap, *National Agreement on Closing the Gap* (2020), https://www.closingthegap.gov.au/national-agreement/national-agreement-closing-the-gap.

	made in writing or in an alternative form via video and must be witnessed and certified by two eligible witnesses.
Health or care entity	A facility which provides health and/or care services to persons who, because of infirmity, illness, disease, incapacity or disability, have a need for nursing or personal care. It includes hospitals, hospices, and residential aged care facilities.
Health practitioner	A person whose profession is regulated under the Australian Health Practitioner Regulation Agency for example doctors, nurses, pharmacists, psychologists, Aboriginal and Torres Strait Islander Health Practitioners.
Healthcare worker	Professionals working in healthcare not necessarily registered under Australian Health Practitioner Regulation Agency (AHPRA), for example speech pathologists, social workers, Aboriginal Liaison Officers working in hospitals.
Life-limiting illness	An active, progressive or advanced disease, that has little or no prospect of cure and that a person is likely to die from at some point in the future.
Medical practitioner	A doctor registered by Australian Health Practitioner Regulation Agency.
Navigation service	A service to provide accessible information and support to individuals considering VAD, their families, caregivers and health professionals and to facilitate connections with participating medical professionals.
Palliative care	Healthcare that focuses on improving the quality of life and quality of care for people with a life-limiting illness.
Practitioner Administration	The method of administration of a VAD substance following a Practitioner Administration Decision in which the person chooses for an Authorised VAD Practitioner to administer the VAD substance to them.
Prognosis	Medical opinion or prediction regarding the expected course and outcome of a disease, injury or illness.
Review Board	The statutory review body created by the NT VAD legislation whose functions include the oversight and monitoring of VAD in the NT.
Self-Administration	The method of administration of a VAD substance following a Self-Administration Decision in which the person chooses to self-administer a VAD substance at a time of their choosing.
Second Assessment	An assessment conducted by the Consulting Practitioner to assess whether the person is eligible for access to VAD by

	determining whether they meet each of the eligibility criteria.
VAD Care Navigator Service (or official VAD Care Navigator Service)	An official VAD service which provides support, assistance and information to people relating to VAD.
VAD Substance	A substance approved for the purposes of providing VAD.
Voluntary assisted dying (VAD)	Where an eligible person chooses to access and receive assistance to die in accordance with the VAD legislation.

Terms of Reference

On 14 May 2025, the Attorney-General requested the Legal and Constitutional Affairs Committee (the Committee) undertake an inquiry into the final report of the Voluntary Assisted Dying Independent Expert Panel, *Voluntary Assisted Dying in the Northern Territory-final report 2024* (the Inquiry).

The Terms of Reference for the Inquiry are to:

- Prepare a consolidated consultation paper, drawing upon previous reports, inquiries, proposals, and the *Rights of the Terminally Ill Act 1995* (NT)
- Consult extensively with communities across the Northern Territory (NT), particularly in remote areas, to gather views on the possible introduction of voluntary assisted dying (VAD) in the NT
- Evaluate different VAD models and safeguards, with a focus on those that would be appropriate for the NT context
- Identify any specific challenges associated with delivering VAD in the NT
- If the Committee recommends adoption, provide drafting instructions for model legislation to give effect to VAD in the NT

The Attorney-General requested the Committee respond by the end of September 2025.

Executive summary

Chapter 1 Introduction

The Legal and Constitutional Affairs Committee (the Committee) received a referral to inquire into the *Voluntary assisted dying in the Northern Territory - final report 2024* from the Attorney-General on 14 May 2025. The terms of reference required the Committee to prepare a consultation paper, consult extensively with communities across the Northern Territory (NT) including remote communities and evaluate various voluntary assisted dying (VAD) models and safeguards. The Committee was also required to identify any challenges to delivering VAD in the NT and provide drafting instructions for model legislation if adoption of VAD legislation was recommended.

A consultation paper was released on 14 July 2025, building on the findings and recommendations of the *Voluntary assisted dying in the Northern Territory - final report 2024* and VAD legislation in other jurisdictions. Written and oral submissions were called for with 411 received. A series of largely remote community consultations were conducted across the NT in August 2025.

This report recommends that VAD legislation be adopted in the NT. It contains the Committee's 86 recommendations including drafting instructions. The instructions were developed in close conjunction with the Australian Centre for Health Law Research, Queensland University of Technology (see Appendix 3).

Key differences to the 2024 report or additions made by the Committee include:

- not requiring a prognosis timeframe for a person to be eligible for VAD;
- the need for the NT Government to develop a palliative care strategy;
- supporting a decentralised rather than centralised VAD model, noting that the service will evolve and mature over time;
- expanding the parameters of institutional conscientious objection to promote cultural safety; and
- expanding immunity from liability to a wider range of workers in the healthcare sector involved in VAD.

There were also issues where the Committee's view diverged from the Australian model of VAD, including:

- embedding cultural safety as a guiding principle in the VAD legislation;
- respecting a person's choice to voluntarily include other people in decision-making about end-of-life choices;
- allowing for alternative modes, including videos, to make formal requests for VAD more accessible;
- embedding greater Aboriginal and Torres Strait Islander representation on a VAD Review Board; and

- expanding protections to other workers in the healthcare sector who conscientiously object to VAD.

Chapter 2 – Intersection of VAD with the existing NT healthcare system

Understanding the unique nature of the NT will be a key determinant of the success of any VAD service in the NT. This includes the delivery of healthcare services.

Several overlapping elements shape the current delivery of healthcare in the NT. The Territory contains some of the most remote communities in Australia. One third of the population identifies as Aboriginal or Torres Strait Islander. The Territory community is also culturally and linguistically diverse. This cultural complexity necessitates dexterity to deliver culturally safe healthcare. The NT's small and dispersed population also has a significantly higher burden of disease and injury than the Australian average. The healthcare system is furthermore challenged by workforce shortages.

A VAD service in the NT will closely intersect with existing healthcare services including aged care, mental health services, disability services and Aboriginal medicine, beliefs and practices. Currently, many of these services are stretched. Careful planning and the allocation of additional resources will be required to ensure VAD services do not add additional pressure to such services.

Chapter 3 – Finishing up well: end of life choices in the NT

The Committee had many discussions in remote and regional communities about what 'finishing up well' and having a 'good death' looks like. The importance of being surrounded by loved ones, retaining personal dignity, being comfortable and returning to Country were common themes. Some advocated for a natural death, that is without any medical intervention, including pain management. For others, continued access to medical treatment right up to the end is a priority.

Unfortunately, for some Aboriginal people living in remote parts of the NT, there is limited choice regarding end-of-life care. The Committee learned of people having to choose between medical treatment or palliative care and returning home, with many opting to withdraw from medical care in order to pass away on Country.

Palliative care in the NT has been described as "woefully insufficient" by NT Health, although the Committee also heard about and inspected some excellent facilities. When VAD services have been introduced in other Australian states, the demand for palliative care has risen sharply. The Committee expects this will also be the case in the NT. Accordingly it has recommended that the NT Government develop a Territory-wide palliative care strategy.

Chapter 4 – VAD service delivery models

Four different VAD service delivery models were explored by the Committee – centralised, community-based (decentralised), hybrid and interjurisdictional shared models.

The 2024 Expert Panel Report recommended the adoption of a centralised model. Under a centralised model, the service would be managed by the NT Government with independent oversight provided by a Review Board. The service would operate separately from current

NT health services and facilities. A dedicated VAD service team would offer an NT-wide service.

A preferred service delivery model is not prescribed in other Australian VAD legislation. The Committee recommends the development of a decentralised service delivery model. Its drafting instructions have been crafted, however, to allow for a variety of models to be adopted.

The Committee shares the view of the 2024 Expert Panel that the VAD service should be co-designed with Aboriginal people. It also notes that VAD service delivery in the NT may evolve over time, as has been the experience in other jurisdictions.

Chapter 5 – Purpose and principles

The 2024 Expert Panel did not recommend defining the purpose of VAD legislation. However, the Committee is of the view that this is important to guide the development of delegated legislation and policy during the implementation phase of VAD.

The Committee recommends the NT VAD legislation states that its purpose is to primarily give people who are suffering and dying and who meet eligibility criteria a legally authorised option to hasten their death by medical assistance. It should provide protections for eligible people seeking VAD and health practitioners who assist, in accordance with the legislation. The Committee has also incorporated recognition of the unique demography and geography of the NT in which VAD will be delivered into its drafting instructions for the legislation.

A series of guiding principles are recommended by the Committee to be reflected in the VAD legislation. These principles align with other pieces of Australian VAD legislation. The main point of difference, however, is that the Committee recommends the principles recognise the importance of cultural safety in relation to VAD. This is not a feature of VAD legislation elsewhere in Australia.

Finally, the Committee clarifies, in line with the Australian model of VAD, that VAD is not suicide and this should be explicitly stated in any legislation.

Chapter 6 – Eligibility criteria

The Committee recommends that five criteria need to be met for a person to be considered eligible for VAD in the NT, namely:

- the decision for VAD is voluntary;
- the person has an advanced and progressive condition which is expected to cause death, and is causing intolerable and enduring suffering that is actual or anticipated;
- the person is either an Australian citizen or has ordinarily resided in Australia for two years and has ordinarily resided in the NT for 12 months, with possible exemptions for cross-border residents and people who have family, cultural or support links to the NT;
- the person must be aged 18 or older; and
- the person must have decision-making capacity in relation to VAD at all stages of the process.

These criteria align with all other Australian jurisdictions in that a person is not eligible solely on the basis of a mental illness or disability.

By recommending that a person should not require a timeframe to death before they can access VAD, the Committee significantly diverges from the recommendation of the Expert Panel and the model of the Australian states that require a 6- or 12- month timeframe. This decision is based on the unreliability of prognosis timeframes and the view that the other medical condition requirements provide sufficient safeguards.

The proposed legislation explicitly specifies that a person should be able to include chosen others in decision-making about end-of-life choices. This recognises that a person may need to follow culturally accepted decision-making practices or may simply want another person to be involved in the process. The requirement for the decision to be voluntary and free from coercion remains paramount.

The Committee aligns with the Australian Capital Territory VAD model in explicitly specifying that suffering includes mental and/or physical suffering, and that such suffering can be anticipated or expected.

The Committee is satisfied that residency requirements will prevent 'VAD tourism'. The Committee is of the view that consideration should also be given to people with a long-standing association or connection to the NT.

Chapter 7 – Request and assessment process

The processes for a person to request VAD and to have their eligibility assessed involves initiating the discussion, a First Request, two separate eligibility assessments by two medical practitioners, and a final Formal Request. In making these recommendations, the Committee regards equity of access as paramount.

A person seeking VAD can at any time, and to any person, initiate a conversation about VAD. However, healthcare workers across Australia have varying levels of restrictions and/or obligations associated with initiating such a discussion. The Committee takes a patient-centred approach, recommending healthcare workers can initiate a discussion about VAD but must also outline other treatment options available, including the option of palliative care.

The Committee recommends the First and Formal Request processes should be generally consistent with other Australian jurisdictions, with the First Request being oral or by other communication means available to a person, and the (second) Formal Request being a signed written request. Flexibility is built in for people who cannot sign the request themselves. The proposed legislation includes a provision that allows Formal Requests to be made via a video recording to acknowledge the cultural preferences that some people, particularly Aboriginal people, may have to 'see consent' rather than read it.

The Committee recognises the critical importance of interpreters in enabling people to fully understand and access VAD and therefore, recommends that interpreters should be available at all stages of the VAD process.

The potential benefits of telehealth in promoting equitable access within the VAD process were examined. The Committee considers that the NT legislation should remain open to

future amendments to the *Criminal Code Act 1995* (Cth) which currently imposes restrictions on the use of telehealth for VAD.

Chapter 8 – Administration of the VAD Substance

The following requirements must be met before the VAD Substance is administered to an eligible person: making of an Administration Decision (Self or Practitioner Administration); selection of a Contact Person, who has responsibilities for the storage, handling, preparation and disposal of the VAD Substance and reporting of the death of the person; processes in place for the safe supply, storage and disposal of the VAD Substance; and presence of a witness at the time of administration.

While the Committee recognises concerns raised about Self-Administration, particularly in remote and vulnerable communities, it considers that Self-Administration should be an option in the NT to balance the considerations of timely access to VAD and the autonomy of the person seeking VAD. The Committee finds that some safeguard requirements for the safe supply, storage and disposal of the VAD Substance should be built into the legislation, noting that other requirements will be more effectively governed by delegated legislation, medication protocols and/or organisation-specific guidelines during the implementation phase.

The Committee recommends strong safeguards against potential misuse of the VAD Substance be put in place, in the event that a person has changed their decision from Self-Administration to Practitioner Administration, by requiring the VAD Substance be returned before Practitioner Administration takes place.

It is proposed to follow the majority of other Australian jurisdictions by not requiring medical practitioners to seek a VAD authorisation permit from the government or Review Board, and by requiring a witness to be present when a practitioner administers the VAD Substance.

Chapter 9 – Steps after death

The Committee determines that VAD deaths should not be treated as reportable deaths. Instead, the Review Board will record all VAD-related deaths and refer only serious cases of non-compliance or complications to the Coroner. This ensures strong oversight without unnecessary administrative burden.

For death certificates, the Committee recommends listing the underlying illness as the cause of death. This protects privacy, avoids stigma, and ensures families are not disadvantaged in matters such as insurance or superannuation. It also helps safeguard healthcare workers, particularly in remote areas, from backlash or blame.

Chapter 10 – Health practitioners' qualifications and training

The Committee examines how qualifications and training requirements for VAD Practitioners can balance accessibility with strong safeguards. It heard that in the NT, the limited size of the healthcare workforce and vast distances make it challenging to meet overly prescriptive requirements. For this reason, the Committee supports the 2024 Expert Panel's recommendation that Coordinating and Consulting Practitioners should be medical practitioners with either five years of general registration or one year of specialist

registration. Requiring specialist expertise for both practitioners is considered unworkable, especially in remote areas.

To improve access and align with other jurisdictions, the Committee supports expanding the role of Administering Practitioners to include nurse practitioners and registered nurses. Nurses are experienced in medication administration and often have close relationships with patients and families, making them well-placed to support VAD delivery, especially in remote communities. The Committee concludes that these measures are vital for building a safe and accessible VAD system for all Territorians.

Mandatory training is identified as an essential safeguard to ensure consistency, quality, and cultural safety in VAD services. Training must go beyond legal compliance to include clinical skills, ethics, communication, and culturally safe practices for Aboriginal and Torres Strait Islander people.

Chapter 11 – Non-participation by healthcare workers and entities

The Committee examines how to balance the rights of healthcare workers to conscientiously object to VAD with the need to maintain access for patients. It emphasises that these rights and obligations should extend beyond doctors and nurses to include other workers in the healthcare system, such as speech pathologists, Aboriginal Liaison Officers, interpreters, social workers, and others who play vital roles in NT healthcare. This reflects the Territory's unique workforce, especially in remote communities. While practitioners may conscientiously object, at a minimum, they must provide information or direct patients to the official VAD navigator service, helping them connect with practitioners who can assist.

Institutional objection is considered more complex, particularly in faith-based hospitals and aged care facilities. The Committee's primary concern is ensuring cultural safety for Aboriginal people and other vulnerable groups. It supports allowing institutions to refuse to provide VAD services, but only if they are transparent about their position, do not block access to information, allow VAD navigators onsite, and help transfer patients when required. This approach seeks to protect institutional and cultural values while ensuring individuals can still make informed choices and access care without unnecessary delays or distress.

Chapter 12 – Accountability, offences and protections

The Committee supports the Expert Panel's recommendation to establish a Review Board to oversee every VAD case, monitor compliance, and report. The NT's Review Board membership should include appropriate medical and legal expertise, as well as Aboriginal representation to ensure cultural safety and regional equity. As a significant departure from other jurisdictions, the Committee recommends the Review Board be chaired by the Chief Health Officer to tap into existing statutory powers and resources.

The Committee supports protecting the right to appeal to the NT Civil and Administrative Tribunal for certain eligibility decisions by a person seeking VAD, as well as their agent or another genuinely interested party.

The Committee proposes clear offences to deter misconduct. In line with other jurisdictions, the Committee supports extending immunity from civil and criminal liability for individuals involved in the VAD process. However, the Committee stresses that legal protections must

match the expanded responsibilities of individuals and healthcare workers under the VAD framework. These measures aim to ensure a safe, transparent, and trusted VAD system for all Territorians.

The VAD legislation itself should be reviewed three years after commencement, and every five years thereafter, to keep it responsive and culturally safe.

Chapter 13 – Other considerations

The Committee highlights several additional measures needed to ensure the VAD framework in the NT is safe, culturally appropriate, and effective. It recommends including miscellaneous provisions in the legislation, such as handling technical errors on forms, clear authorisation powers for NT Health, and proper notification processes. These provisions, although minor, are essential for the legislation to function smoothly.

An 18-month implementation period is endorsed, consistent with other jurisdictions and the 2024 Expert Panel Report, to allow time to set up key systems such as the Review Board, and for training to occur. A culturally safe public education campaign is also seen as critical to raise awareness and counter misinformation, particularly in remote and Aboriginal communities. Resources must be multilingual, accessible, and developed with community consultation.

Beyond the legislation, regulations and clinical guidelines will be needed to provide practical guidance for practitioners and ensure consistency in medication handling, training, and care standards. These should be developed in close consultation with Territorians and regularly reviewed, with cultural safety principles embedded throughout. This broader regulatory framework will ensure VAD is delivered safely and equitably across the NT

1 Introduction

Background to the Inquiry

1.1 Voluntary Assisted Dying (VAD) is the use of a prescribed substance to cause the death of a person who is terminally ill at their request. It is a process that gives an eligible person the choice to ask for medical help to end their life in a manner and time of their choosing. VAD is not a way for a person who is not terminally ill to end their life. 'Voluntary' means the process can be freely chosen by a person who is competent to make decisions about VAD. VAD is one of many end-of-life choices. Others may include continuing treatment or palliative care.

1.2 VAD is not currently legal in the Northern Territory (NT), and it is an offence to assist another person end their life.[2] VAD was briefly legal in the NT under the *Rights of the Terminally Ill Act 1995* (ROTI Act). Under the ROTI Act, the NT became the first Australian jurisdiction to legalise VAD. However, the ROTI Act was overturned by the Federal Parliament in 1997, with all Territories prohibited from making VAD legislation.[3] The Commonwealth lifted this ban in 2022, and the NT can legislate on VAD again.[4]

1.3 In August 2023, the Voluntary Assisted Dying Independent Expert Panel (Expert Panel) was established by the Chief Minister to inquire into and report on developing VAD legislation in the NT. In August 2024, the Expert Panel delivered its final report, *Report into Voluntary Assisted Dying in the Northern Territory* (2024 Expert Panel Report). The 2024 Expert Panel Report made 22 recommendations relating to eligibility, process, oversight, and implementation of potential VAD legislation in the NT.

Inquiry Referral

1.4 The Legal and Constitutional Affairs Committee (the Committee) of the NT Legislative Assembly conducts inquiries into and reports on constitutional and legal matters referred to it by the Attorney-General or the Legislative Assembly.

1.5 On 14 May 2025, the Attorney-General requested the Committee undertake an inquiry into the 2024 Expert Panel Report (the Inquiry). The Attorney-General requested the Committee respond by the end of September 2025.

Outcome of the Committee's Consideration

1.6 End-of-life choices may raise complex and challenging questions. VAD is an important ethical, social and legal issue for people in the NT, with many arguments for and

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[2] *Criminal Code Act 1983* (NT), s 162.

[3] *Euthanasia Laws Act 1997* (Cth), s 3, schs 1-3. The *Euthanasia Laws Act 1997* (Cth) amended relevant federal legislation to remove the ability of the NT, the Australian Capital Territory and Norfolk Island to enact assisted dying legislation in the future.

[4] In December 2022, the Commonwealth Parliament passed the *Restoring Territory Rights Act 2022* (Cth). For more information see Parliament of Australia, *Bills Digest No. 5, 2022-23* (2023), https://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/bd/bd2223a/23bd005.

against its use. The Committee acknowledges the sensitive nature of discussing VAD and values the diverse perspectives of stakeholders who contributed to the Inquiry.

1.7 The 2024 Expert Panel Report recommended the NT should implement VAD legislation that is broadly consistent with VAD legislation in other Australian States and Territories.[5] The Committee considered this recommendation throughout the course of the Inquiry. This section outlines the outcome of the Committee's consideration.

Approaches in other jurisdictions

1.8 The Committee observes that VAD has been legislated in all Australian States and the ACT.[6] The VAD legislation across Australian jurisdictions shares similar basic features, giving rise to a general 'Australian model'. These features are discussed in detail throughout this Report and include:

- **Eligibility criteria** for accessing VAD, including minimum age, residency, suffering, voluntariness, prognosis[7] and decision-making capacity.
- **Process** for independent assessment of eligibility by two qualified and experienced health practitioners.
- **Administration of the VAD Substance** prescribed by a health practitioner, either via Self-Administration or administration by a health practitioner on the person's request.
- **Conscientious objection** by health practitioners who do not wish to participate in VAD.
- **Accountability** by oversight provisions, including reporting, monitoring by an oversight body and compliance enforcement.[8]

1.9 VAD legislation in other jurisdictions is also accompanied by delegated legislation and guidelines.

Evidence before the Committee

1.10 The Committee heard wide-ranging views about the potential implementation of VAD in the Territory. Whilst the views expressed were highly diverse, there was a consistent emphasis on the importance of choice regarding VAD.[9] Across the NT the Committee heard about the importance of "help and choice to finish up well".[10] In

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[5] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), Recommendation 1.

[6] *Voluntary Assisted Dying Act 2017* (Vic); *Voluntary Assisted Dying Act 2019* (WA); *End-of-Life Care* (*Voluntary Assisted Dying) Act 2021* (Tas); *Voluntary Assisted Dying Act 2021* (SA); *Voluntary Assisted Dying Act 2021* (Qld); *Voluntary Assisted Dying Act 2022* (NSW); *Voluntary Assisted Dying Act 2024* (ACT).

[7] The ACT is an outlier in this regard, setting no set timeframe to death.

[8] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 56-60.

[9] Meetings with community representatives, Numbulwar, Barunga, Borroloola, Ngukurr, Papunya, and Wurrumiyanga, August 2025.

[10] Meeting with Mabunji Aboriginal Resource Indigenous Corporation, Borroloola, 7 August 2025.

Borroloola, Brian Hume, Deputy Chairperson of Mabunji Aboriginal Resource Indigenous Corporation stated:

> No one community is the same. There are difficult dialects; different ways of doing things. [VAD] is a very sensitive issue, so it is different for each individual.[11]

1.11 Tiwi Elder, Teddy Portaminni expressed the view that end-of-life choices, and particularly choices regarding VAD, must ultimately rest with the individual:

> For me to say, 'No, I do not want it'—I do not want that to happen here again, but it is up to the people themselves. If they say yes to it, then it is their choice. We cannot force people.[12]

1.12 In some remote communities, the Committee heard that individuals would like the option of VAD as one end-of-life choice.[13] In other communities, the Committee heard that individuals did not want VAD for themselves but supported the right of others to choose it.[14] In Barunga, an Elder (via a Kriol interpreter) noted:

> …if [non-Aboriginal] people want to do that then that is their choice. But we Aboriginal people we have the belief that we should finish on our own, like even if we are suffering and in so much pain, this is part of life for us.[15]

1.13 In Papunya, former Member of the Legislative Assembly, Alison Anderson told the Committee:

> …if people outside of us want it, they can have it, but not for us. It is not for us, and I cannot stress that enough.[16]

1.14 The Committee also heard that different views were often held within the same community. In Borroloola, a Local Authority member reflected on the inevitability of disagreement, while reinforcing the principle of choice:

> Every decision is going to have two opposing sides. I know [one community member] would have been very happy to have a part in this. Other people may disagree, and they can, but you cannot stop people from having a choice. I would.[17]

1.15 Overall, the Committee heard support for legislating VAD. The views of stakeholders who were in support of VAD were informed by the desire for choice in end-of-life care.[18] Many submitters suggested that VAD would help to alleviate unbearable suffering and would enable greater dignity for people with terminal illnesses. Steven O'Grady, an NT resident in palliative care, stated:

> Mercy being what separates us from nature, and as the 'golden rule' states that you do unto others as you would have them do unto you. The notion of mercy is to ease suffering. I've been on radio lately to ask listeners to have this very important conversation to enable agreement that freedom, justice and mercy are mere human constructs, yet define law and empathy and humanity, during the long game… If you saw and smelled my wound, you would feel my pain and loss

[11] Meeting with Mabunji Aboriginal Resource Indigenous Corporation, Borroloola, 7 August 2025.
[12] Meeting with community representatives of Wurrumiyanga, Darwin, 18 August 2025.
[13] Meeting with Borroloola Local Authority, Borroloola, 7 August 2025.
[14] Meetings with community representatives, Barunga, 12 August 2025 and Papunya, 20 August 2025.
[15] Meeting with community representatives, Barunga, 12 August 2025.
[16] Meeting with community representatives, Papunya, 20 August 2025.
[17] Meeting with Borroloola Local Authority, Borroloola, 7 August 2025.
[18] Submissions 23, 24, 44.

> of independence. Be careful what you ask… A young victim of an accident might not want to be where I am now… existing.[19]

1.16 NT resident, Raemyn Carrick, described her husband's choice to use VAD in Queensland:

> After confirming that he understood that he was going to die, he said I promise I won't snore. I cradled him in my arms and in two breaths, he snored and was gone. I couldn't help but giggle as my eyes welled with tears, at last he was at peace. If there is such a thing as a beautiful death that was it. Yes. It was sad and I still feel my loss every day, but I totally respect my husband's choice to end his suffering and am so grateful that Queensland has this opportunity in place for those who need it and wish to end their lives on their own terms and with dignity.[20]

1.17 Many other stakeholders emphasised the issue of equity, noting that the NT is the last jurisdiction to consider legalising VAD.[21] These stakeholders noted that NT residents should not be "second class" or "disadvantaged" citizens.[22] NT resident, Sonja Pastor said:

> The NT remains the only jurisdiction in Australia without access to VAD, which creates inequality and forces people to either endure suffering or relocate interstate to exercise a choice that is available elsewhere. The NT has a proud history of leading the world on this issue, as the first place to pass a VAD law in 1995. Reintroducing a safe, modern framework would align with contemporary values of compassion, autonomy, and respect for personal choice, while ensuring the strongest safeguards.[23]

1.18 The Committee heard frustration at the Federal restrictions on territories legislating VAD.[24] Many residents expressed the view that legislating VAD was overdue in the NT. NT resident, Andrew Roberts argued:

> [VAD] legislation is long overdue in the NT. With every other state and territory implementing VAD, Territorians deserve the same rights and protections. A model grounded in compassion, equity, and cultural safety will ensure the law respects individual dignity while protecting vulnerable people.[25]

1.19 Regarding her late husband's use of VAD under the ROTI Act, Judy Dent, President of the NT Voluntary Euthanasia Society noted:

> Unfortunately for the rest of the Territory, the federal government decided that we should not have such a law. How dare we? It has taken more than 25 years to get back the right for us to have that legislation again.[26]

1.20 Many stakeholders noted the NT was the first jurisdiction to introduce VAD. In this regard, the Committee notes there is great pride associated with the name 'Rights of the Terminally Ill Act'.[27] NT resident, Caroline Cavanaugh stated:

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[19] Submission 49.
[20] Submission 1.
[21] Submissions 2, 4, 6, 11, 15, 17, 23, 24, 25, 26, 27, 28, 31, 33, 34, 35, 39, 41, 42, 43, 44, 46, 62, 69, 70, 71, 94, 196, 388; Judy Dent, Public Hearing, Darwin, 5 August 2025.
[22] Submission 34.
[23] Submission 21.
[24] Meetings with community representatives, Ngukurr, 6 August 2025 and Barkly Regional Council and Tennant Creek Local Authority, Tennant Creek, 27 August 2025.
[25] Submission 4.
[26] Judy Dent, Public Hearing, Darwin, 5 August 2025.
[27] Submission 4.

> I recommend retaining the expression 'rights of the terminally ill' as the title of a VAD law as that strengthens the focus on to the person. It is their right to choose and using the term 'rights' is a self-empowering statement. This would deflect criticism away from 'voluntary assisted dying' which could have a negative connotation, rather, it is focused towards a person having control over their end of life experience. This reflects contemporary policies and principles of people's rights in the health sector.[28]

1.21 However, many stakeholders to the Inquiry did not support VAD, with a majority of these stakeholders citing their religious beliefs as the main reason for their opposition.[29] A number of these submitters noted that life is precious.[30]

1.22 Some stakeholders were concerned about the cost of implementing VAD in the NT, raising that VAD may take away resources from other much needed healthcare priorities.[31] Many submitters suggested that greater emphasis should be placed on delivering high quality palliative care to Territorians.[32] This emphasis on palliative care was similarly echoed by certain healthcare professionals, who held philosophical opposition to VAD on the basis that healthcare should be life-saving care.[33] This issue is discussed in Chapter 3.

1.23 Some stakeholders to the Inquiry suggested that legislating VAD in the NT would have a negative impact on Aboriginal people.[34] These stakeholders argued:

- Many Aboriginal people have mistrust in health services and VAD would have the potential to discourage Aboriginal people from seeking healthcare;[35]
- There is a clash between Aboriginal cultural beliefs and VAD;[36]
- Aboriginal people may face unique vulnerabilities that make them more susceptible to coercion to choose VAD;[37] and
- Language and cross-cultural communication barriers will create misunderstandings and misinformation.[38]

1.24 The Committee observes that these fears did not always stem from Aboriginal people themselves, but rather from non-Aboriginal people, though some of whom have experience in Aboriginal healthcare. The Committee notes that it observed much more varied and nuanced feedback from Aboriginal stakeholders to the Inquiry. These perspectives are addressed throughout this Report.

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[28] Submission 95.
[29] Submissions 116, 141, 142, 240, 271, 293, 305, 306, 315, 334, 386.
[30] Submission 86.
[31] Submissions 110, 175
[32] Submissions 148, 227, 244, 293, 307, 334, 387.
[33] Submission 331.
[34] Submissions 57, 67, 81, 92, 97, 142, 164, 249, 250, 251, 317.
[35] Submissions 331, 109.
[36] Submission 81.
[37] Submission 67.
[38] Submissions 57, 92

1.25 Some stakeholders pointed to the idea that the introduction of VAD would be a "slippery slope" towards expanding the categories of VAD to other vulnerable populations.[39] This issue is discussed in Chapter 6.

1.26 The Committee observed that a number of stakeholders did not have a view either in support of, or in opposition to, the introduction of VAD legislation in NT. Several of these stakeholders noted that this was because they represent diverse memberships with varying views and, as such, chose not to take a formal position.[40] These stakeholders instead noted that the legislation of VAD would require consideration of how it would intersect with other issues, including:

- certain medical conditions;[41]
- Aboriginal healthcare;[42]
- religious freedom;[43]
- issues affecting older people;[44] and
- grief and bereavement effects on people seeking VAD and their families.[45]

1.27 Some stakeholders shared experiences from other jurisdictions without presenting views on whether VAD legislation should be introduced in the NT.[46]

Committee comments

1.28 The Committee recognises the diverse views of Territorians on this topic and acknowledges the sincerity and passion with which these views were put forward to this Inquiry. After reviewing the evidence presented throughout the Inquiry and the models adopted in other jurisdictions, the Committee recommends legislating VAD in the NT, in line with Recommendation 1 of the 2024 Expert Panel Report.

1.29 The Committee makes this recommendation, noting that there must be strong safeguards, a commitment to cultural safety and robust oversight mechanisms in place. In this regard, the Committee notes that the legislation must balance personal autonomy with community safety in providing Territorians with compassionate end-of-life choices. The Committee's recommendations for how this can be achieved are incorporated in drafting instructions throughout this report, developed in collaboration with the Australian Centre for Health Law Research at the Queensland University of Technology (QUT).

1.30 The Committee notes that the NT is now the last Australian jurisdiction to introduce a VAD framework and acknowledges the Territory's unique history as the first Australian jurisdiction to legislate in this area through the ROTI Act. Many Territorians

[39] Submissions 81, 112, 148, 150, 262, 279, 375.
[40] Submissions 106, 159, 168, 171, 179, 182, 208, 214, 300, 389, 403.
[41] See for example, Submission 106.
[42] See for example, Submissions 403, 37.
[43] See for example, Submission 214.
[44] See for example, Submission 389.
[45] See for example, Submission 384.
[46] See for example, Submission 132.

still hold a strong attachment to the use of the terminology 'rights of the terminally ill' and to the principles of compassion and dignity that underpin it.

1.31 The Committee commends the extensive work of the 2024 Expert Panel Report and has sought to build on and critically examine the model it proposed. Table 1 below outlines where the Committee supports, does not support, or supports in part, each of the 2024 Expert Panel Report recommendations.

1.32 The Committee also identified a number of issues where the 2024 Expert Panel Report was silent or did not make a recommendation. In these instances, the Committee considered the approaches in other jurisdictions and the evidence presented before the Committee to make a recommendation. Key differences or additions by the Committee include:

- not requiring a prognosis timeframe for a person to be eligible for VAD;
- the need for the NT Government to develop a palliative care strategy;
- supporting a decentralised rather than centralised VAD model, noting that the service will evolve and mature over time;
- expanding the parameters of institutional conscientious objection to promote cultural safety; and
- expanding immunity from liability to a wider range of healthcare workers involved in VAD.

1.33 There were also issues where the Committee's view diverged from the Australian model of VAD, including:

- embedding cultural safety as a guiding principle in the VAD legislation;
- respecting a person's choice to voluntarily include other people in decision-making about end-of-life choices;
- allowing for alternative modes, including videos, to make Formal Requests for VAD more accessible;
- embedding greater Aboriginal and Torres Strait Islander representation on a VAD Review Board; and
- expanding protections to other workers in the healthcare sector who conscientiously object to VAD.

Recommendation 1

The Committee recommends that the Government draft legislation to introduce voluntary assisted dying in the Northern Territory as per the drafting instructions set out in this Report.

Recommendation 2

That Committee recommends that the Government name the legislation the Rights of the Terminally Ill Act.

Table 1: Committee's position on 2024 Expert Panel Report recommendations

	2024 Expert Panel Report Recommendation	Committee position	Relevant chapter of Committee Report
1	NT should implement VAD legislation that is broadly consistent with VAD legislation in other Australian States and Territories	Supported	All chapters
2	NT should develop and fund a single, centralised service for the delivery of VAD. This should include VAD practitioners, pharmacists and care navigators. Due to the very specific cultural safety concerns related to provision of VAD, the service should be stand-alone, and clearly separate from existing NT Health facilities.	Not supported Not supported	Chapter 4 – VAD service delivery models
3	VAD assessments must be conducted by appropriately trained medical practitioners only. VAD practitioners must undergo mandatory training and hold appropriate qualifications	Supported Supported	Chapter 10 – VAD Health practitioners' qualifications and training
4	Health professionals should be allowed to conscientiously object to participating in any VAD framework under NT legislation. Conscientious objectors should be required to inform requesting patients of VAD services. Residential facilities may not hinder residents from accessing VAD on site.	Supported Supported Not supported	Chapter 11 – Non-participation by healthcare workers and entities
5	Interpreters must be accredited in order to provide interpreter services in VAD. At every stage of the VAD process, where an interpreter is used, their involvement should be documented and the interpreter should certify their participation accordingly.	Supported Supported	Chapter 7 – Request and assessment process
6	The process for addressing Aboriginal and Torres Strait Islander cultural safety issues needs to be designed and resourced as a core part of the operationalisation of VAD.	Supported	Chapter 4 – VAD service delivery models

7	Recognising the importance of palliative care services in the NT: • A person who requests VAD must be informed of all treatment options including the nature, scope and availability of palliative care services. • Further resources should be provided to educate the community about the nature and scope of palliative care options, particularly for people who wish to remain at home. • Palliative care services must be consistently and adequately resourced to provide specialised and holistic palliative care to patients, wherever they live in the NT and to address the gaps in those services that result in inequities in people's end-of-life options. Implementation of VAD services in the NT must be complementary to, not at the expense of, expanded palliative care resources.	Supported Supported Supported	Chapter 3 – Finishing up well: End-of-life choices
8	To access VAD in the NT, a person should have ordinarily resided in Australia for two years and in the Territory for 12 months. Exceptions should apply for cross-border communities and those with personal connections to the NT, particularly in relation to family, cultural and/or support links.	Supported	Chapter 6 – Eligibility requirements
9	To access VAD in the NT, a person should be aged 18 years or older	Supported	Chapter 6 – Eligibility requirements
10	To access VAD in the NT, a person should have a serious and incurable condition which is causing intolerable and enduring suffering that cannot be relieved in a manner they feel is acceptable. VAD eligibility should be based on a prognosis of 12 months at the time of being assessed, irrespective of diagnosis and if the patient meets all other requirements.	Supported in part Not supported	Chapter 6 – Eligibility requirements
11	To access VAD in the NT, a person must have decision-making capacity at all stages.	Supported	Chapter 6 – Eligibility requirements

	VAD should not be available for persons solely diagnosed with a mental illness	Supported	
12	Medical practitioners should be allowed to introduce the subject of VAD services to patients during discussion about treatment options.	Supported	Chapter 7 – Request and assessment process
13	Subject to amendment of Commonwealth legislation, telehealth should be permitted for VAD purposes provided at least one assessment is conducted in person.	Supported	Chapter 7 – Request and assessment process
14	VAD assessment process should involve two stages of assessment conducted by appropriately qualified medical practitioners.	Supported	Chapter 7 – Request and assessment process
15	Following the assessment phase, the person must make a formal request for VAD in writing which is independently witnessed. Provision should be made where a person is physically unable to provide a formal written request. The timeframe before a formal request may be made should be broadly consistent with timeframes in VAD legislation in other Australian jurisdictions.	Supported Supported	Chapter 7 – Request and assessment process
16	The VAD process should not require the issuing of a permit but rather allow the Coordinating Practitioner to approve the request and issue a prescription, subject to strict reporting requirements	Supported	Chapter 8 – Administration of the VAD Substance
17	The VAD legislation should provide for safe supply, storage and disposal of the substance, including a contact person for VAD. The VAD legislation should provide for a contact person to be appointed by a person who elects Self-Administration for VAD.	Supported Supported	Chapter 8 – Administration of the VAD Substance
18	The Contact Person and Coordinating Practitioner must notify the Review Board of all deaths of persons who have made a formal request for VAD. Notification to the Coroner should not be specifically required.	Supported Supported	Chapter 9 – Steps after death

	The cause of death of a person who has died by VAD should be the underlying disease or illness that would have led to the person's death without VAD.	Supported	
19	An independent statutory body (Review Board) should be established to monitor compliance in every case and to review the operation of the Act. The functions, membership and responsibilities of the Review Board should be as outlined in Chapter 6 of the 2024 Expert Panel Report.	Supported in part	Chapter 12 – Accountability, offences and protections
20	There should be a right of review to the NTCAT for some VAD decisions on eligibility, limited to only the person seeking access to VAD. The VAD legislation should expressly preserve the inherent jurisdiction of the Supreme Court.	Supported Supported	Chapter 12 – Accountability, offences and protections
21	The first review of the operation of the NT VAD legislation should be delivered as soon as practicable after the third anniversary of its commencement. After that, reviews should be conducted at five year intervals.	Supported	Chapter 12 – Accountability, offences and protections
22	VAD services should be ready for operational implementation within 18 months of the legislation being enacted.	Supported	Chapter 13 – Other considerations

Conduct of the Inquiry

Private briefings

1.34 The Committee received a number of private briefings to gather background information at the preliminary stages of its Inquiry. The Committee was briefed by the following individuals and organisations:

- Former Co-Chairs of the Expert Panel, Hon Vicki O'Halloran AO CVO and Mr Duncan McConnel SC (7 July 2025);
- Former Expert Panel member and VAD subject matter expert, Dr Geetanjali Lamba (7 July 2025);
- Remote Information and Engagement Team of the Department of Housing, Local Government and Community Development (7 July 2025); and
- Go Gentle Australia (28 July 2025).

1.35 The Committee also invited input from the Aboriginal Land Councils and the Aboriginal Medical Services Alliance Northern Territory (AMSANT) at the beginning of the Inquiry.

Consultation Paper

1.36 The Terms of Reference require the Committee to prepare a consolidated consultation paper, drawing upon previous reports, inquiries, proposals, and the ROTI Act.

1.37 On 14 July 2025, the Committee published its Consultation Paper on its website. The Consultation Paper comprehensively outlined key issues and background information to assist individuals and organisations making a submission to the Inquiry, addressing each of the recommendations of the 2024 Expert Panel Report.[47]

1.38 In addition, the Committee published a Short Consultation Guide, which set out four key questions for submitters to address.[48] The Committee translated the document into several languages, including:

- Translated written versions in foreign languages (Greek, Nepalese, Filipino and Simplified Chinese)
- Interpreted audio versions in several Aboriginal languages (Eastside Kriol, Yolngu Matha, Kunwinjku, Alyawarr, Burarra, Pintupi Luritja, and Central Eastern Arrente).

Submissions

1.39 On 14 July 2025, the Committee opened its Call for Submissions. Initially, the Committee sought submissions by 15 August 2025. On 12 August 2025, the Committee resolved to extend the due date for submissions until 29 August 2025.

1.40 The Committee wrote to 232 stakeholders to invite them to make written submissions to the Inquiry and to invite other interested stakeholders to contribute.[49] The Committee received 411 written submissions (Appendix 1).

1.41 To enable greater accessibility to the Inquiry process, the Committee invited the community to make verbal submissions via its VAD Inquiry Hotline. The Committee received eight verbal submissions from interested individuals.

1.42 The Committee received submissions from across the NT, Australia and internationally as set out in Table 2 below.

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[47] Legal and Constitutional Affairs Committee, *Voluntary Assisted Dying in the Northern Territory - Consultation Paper* (2025).

[48] Legal and Constitutional Affairs Committee, *Short Consultation Guide – Inquiry into Voluntary Assisted Dying* (2025).

[49] For a full list of stakeholders invited to make a submission, see Appendix 1 of the Committee's first interim report, *Voluntary Assisted Dying in the Northern Territory - First Interim Report* (2025).

Table 2: Submissions received by jurisdiction[50]

Jurisdiction	Number of Submissions Received
Northern Territory	261
Queensland	41
New South Wales	30
Australian Capital Territory	21
Victoria	13
South Australia	11
Tasmania	5
Western Australia	3
International	3

Public hearings, meetings, site visits and community consultation

1.43 The Committee consulted widely with communities across the NT, with a particular focus on remote communities (see Figure 1). A full summary of the Committee's consultation is included in Appendix 2 of this Report. The Committee met with 211 witnesses at the following locations across the NT (either in person or via video/phone link), including:

- Darwin
- Ngukurr
- Borroloola
- Barunga
- Wurrumiyanga
- Gunbalanya
- Papunya
- Alice Springs
- Maningrida
- Numbulwar
- Tennant Creek

1.44 Consultation took a variety of formats, including public hearings, private meetings/briefings, and open public forums. Details of the consultations are set out in Appendix 2. The highest number of contributors by postcode came from parts of Alice Springs and Central Australia. The modes of public consultation are set out in Table 3.

[50] Some submitters did not provide their postcodes to the Committee and have not been counted in these numbers.

Table 3: Modes of public consultation

Mode of Appearance	Number of Witnesses
In-person in remote and regional communities	173
Via phone/video link	24
In-person in Darwin	14
Total	211

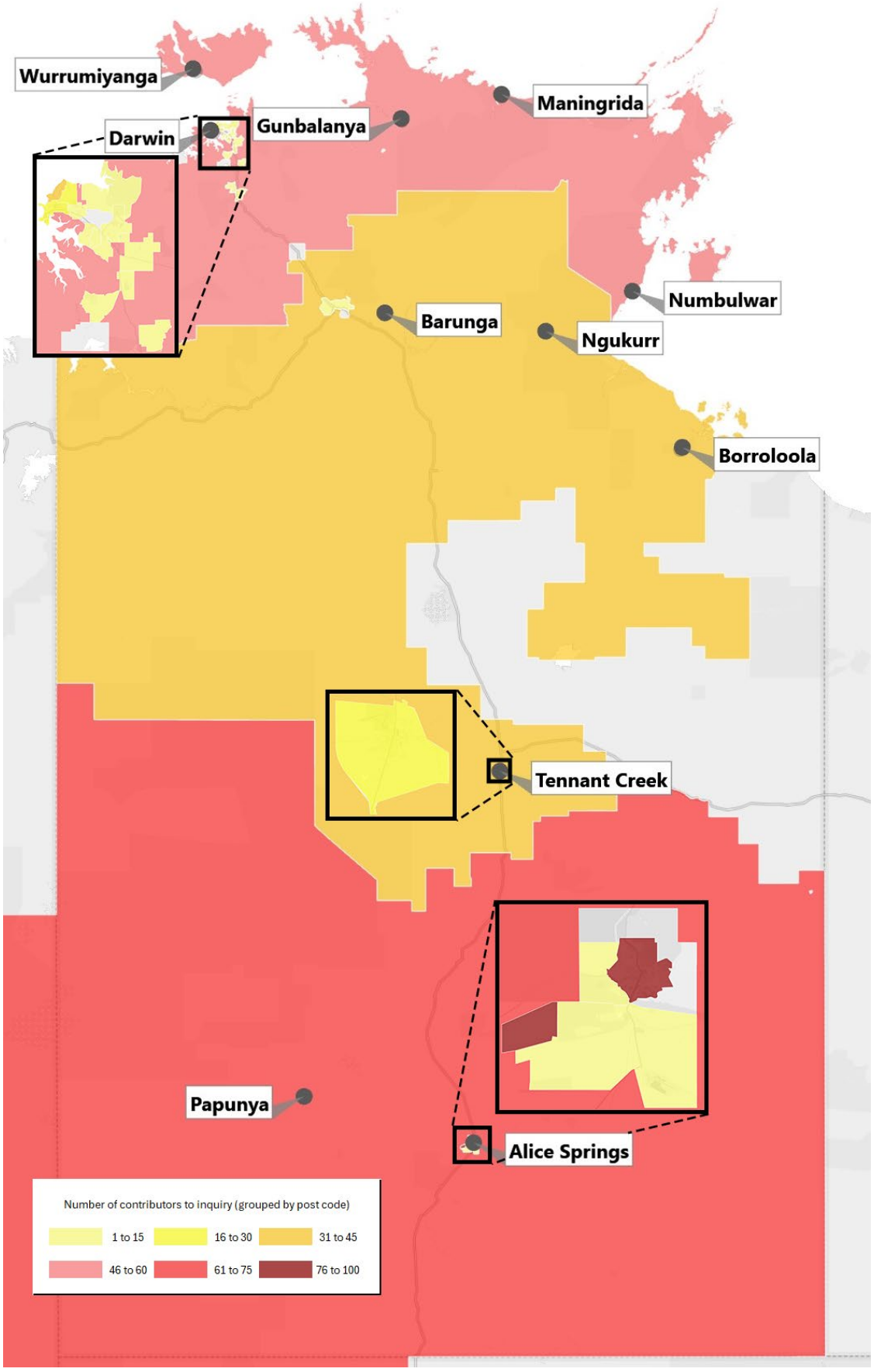
1.45 The Committee attempted to incorporate culturally safe practices in its consultations by:

- undertaking training in end-of-life law, Aboriginal and Torres Strait Islander palliative care and end-of-life choices, and vicarious trauma;
- seeking input from Aboriginal Land Councils and AMSANT;
- engaging the Aboriginal Interpreter Service (AIS), including producing consultation materials in language and working with local interpreters to facilitate on-site consultation in remote communities;
- ensuring support services were available to witnesses;
- gaining the support of local trusted community leaders and cultural brokers to facilitate consultation; and
- Committee staff attending remote engagement training run by the Department of Housing, Local Government and Community Engagement, including working with the AIS training.

1.46 The Committee was working to significant time constraints, limiting its engagement, the work of interpreters, and communities' access to some materials. In Ngukurr, the Committee heard "it was short notice".[51]

[51] Meeting with St Matthews Anglican Church, Ngukurr, 6 August 2025.

Figure 1: Number of Contributors to the Inquiry Across the NT



Interim reports

1.47 The Committee has been committed to ensuring the Inquiry is a transparent and open process. Recognising the complexity of the issues under consideration and the fact that many Territorians have a strong interest in the outcome of its Inquiry, the Committee has sought to keep the community informed of its progress. To that end, the Committee tabled its First Interim Report on 30 July 2025[52] and its Second Interim Report on 2 September 2025.[53] Both are available on the Committee's website.

Appointment of Expert Advisors

1.48 The Committee appointed specialist advisors to aid it in the technical aspects of its Inquiry. On 7 July 2025, the Committee appointed Dr Geetanjali Lamba as a clinical subject matter expert on VAD in the NT. Dr Lamba provided background information on the unique NT context and how this impacts on the delivery of health services across the regions. She reviewed the Committee's public facing documents for technical accuracy. The Committee met with Dr Lamba on 7 and 28 July and 1 September 2025.

1.49 On 23 July 2025, the Committee appointed a team of specialist legal advisors from QUT to assist with preparing drafting instructions for model legislation to give effect to VAD in the NT, should the Committee recommend adoption. The Committee has been assisted by:

- Professor Ben White, Academic Lead, Professor of End-of-Life Law and Regulation;
- Dr Madeleine Archer, Academic Team, Postdoctoral Research Fellow;
- Katherine Waller, Project Staff, Project Manager – VAD Training
- Dr Katrine Del Villar, Academic Team, Senior Lecturer; and
- Denisha Tyler, Project Staff, Research Assistant.

1.50 The Committee met with the specialist legal advisors on 18 and 25 August, and 8 and 15 September 2025. A copy of the drafting instructions can be found in Appendix 3.

Report Structure

1.51 The Report is structured as follows:

- Chapter 1 – Introduction
- Chapter 2 – Intersection of VAD with the existing NT healthcare system
- Chapter 3 – Finishing up well: End-of-life choices
- Chapter 4 – VAD service delivery models

[52] Legal and Constitutional Affairs Committee, *Voluntary Assisted Dying in the Norther Territory – First Interim Report* (2025).
[53] Legal and Constitutional Affairs Committee, *Voluntary Assisted Dying in the Norther Territory –Second Interim Report* (2025).

- Chapter 5 – Purposes and principles
- Chapter 6 – Eligibility requirements
- Chapter 7 – Request and assessment process
- Chapter 8 – Administration of the VAD Substance
- Chapter 9 – Steps after death
- Chapter 10 – Health practitioners' qualifications and training
- Chapter 11 – Non-participation by healthcare workers and entities
- Chapter 12 – Accountability, offences and protections
- Chapter 13 – Other considerations

2 Intersection of VAD with the existing NT healthcare system

Overview

2.1 The NT has unique features that may impact on how VAD can be legislated and delivered, including the complex legal and policy landscape of healthcare provision. In considering the legislation and implementation of VAD in the NT, it is essential to consider the impact it would have on the broader framework of healthcare delivery. This Chapter examines the NT's healthcare context, including the key challenges that must be considered when implementing VAD and key intersecting health services.

Challenges to healthcare delivery in the NT

2.2 The NT faces some significant challenges to healthcare delivery, including remoteness, workforce shortages, a high burden of disease and cross-cultural challenges. [54]

Remoteness

2.3 The NT covers an area of 1.42 million square kilometres but only has a population of 262,000 people. More than 45 per cent of the population live in rural and remote areas with 75 per cent of NT Aboriginal people living in remote or very remote areas.[55] This is significantly more than the national average of 28 per cent.[56]

2.4 NT Health is responsible for six public hospitals in Greater Darwin, Alice Springs, Tennant Creek, Katherine and Gove. Additionally, NT Health supports 39 primary healthcare centres and supports 133 clinics/services operated by Aboriginal Community Controlled Health Services (ACCHSs).[57] Administratively, the NT is divided into five regions, as illustrated in Figure 2.

2.5 Many patients and healthcare workers need to travel vast distances to access or provide healthcare services.[58] This travel is often complicated by infrastructure challenges, including damaged roads, and road or airstrip closures during the Wet Season.[59] The Mayor of West Arnhem Regional Council, James Woods, told the Committee:

> …we make up 30% of the Territory—in remote areas, the challenges could be the people in remote areas may have trouble accessing the service due to distance.[60]

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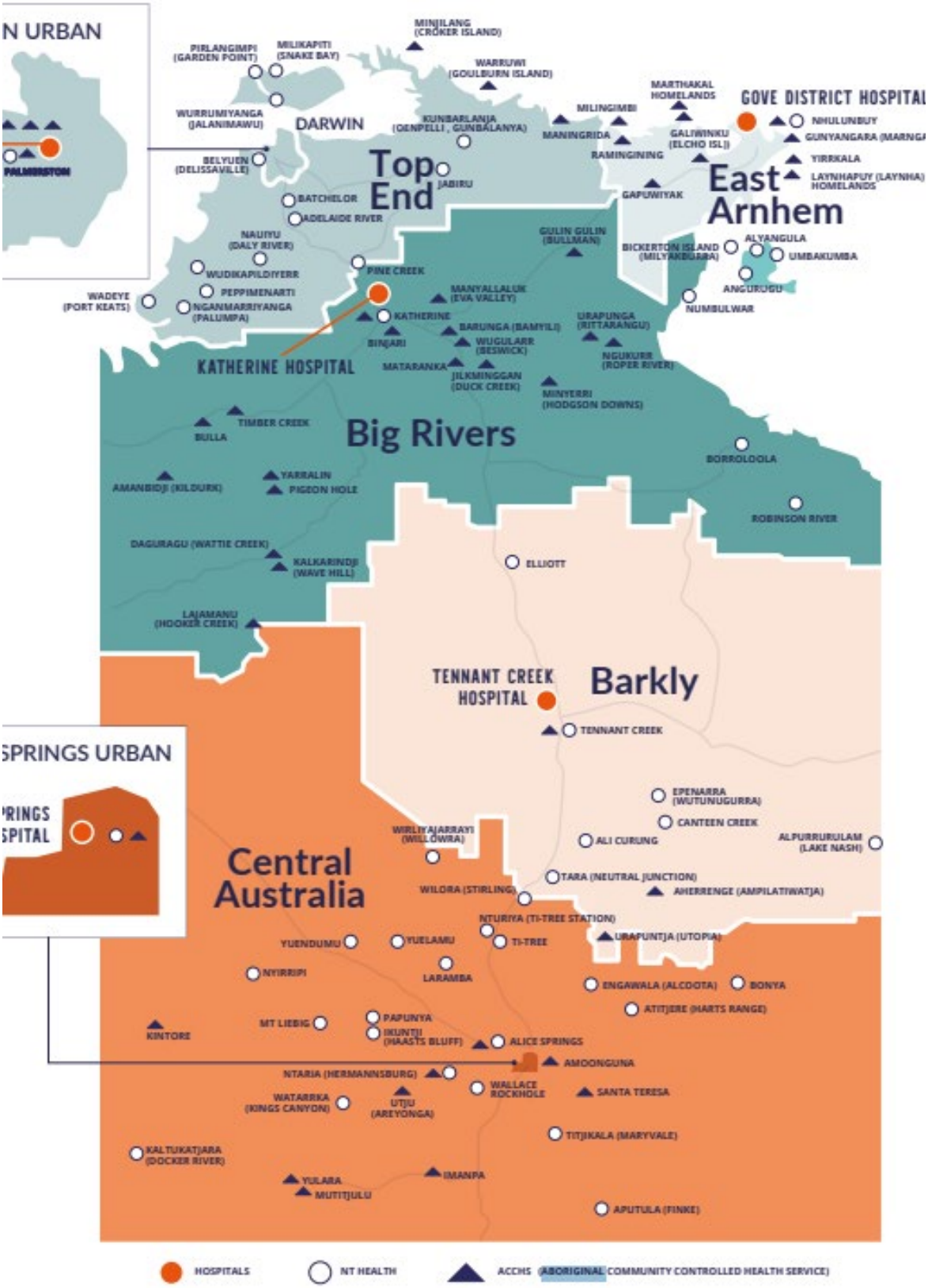
[54] NT Health, *Strengthening our Health System Strategy (2020 - 2025)* (2020), p. 6, 10.
[55] G. Lamba et al., 'Voluntary assisted dying: challenges in Northern Territory remote Aboriginal communities' (2025) 223(6) *The Medical Journal of Australia* 292–295.
[56] Australian Institute of Health and Welfare, *Rural and remote health* (2024), https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health.
[57] NT Health, *Strategic Plan 2023-2028* (2023), p. 7.
[58] See for example, Submissions 321, 368, 376, 389; Meetings with Gunbalanya School Board and staff, Gunbalanya, 19 August 2025 and Alice Springs Hospital Palliative Care team, Alice Springs, 21 August 2025.
[59] Meeting with Gunbalanya School Board and staff, Gunbalanya, 19 August 2025.
[60] Meeting with community representatives of Maningrida, Darwin, 25 August 2025.

Figure 2: NT Health service locations by region[61]



2.6 The Committee heard that these distances and infrastructure deficits often prohibit regional and remote residents from being able to access the services they need.[62]

Whilst telehealth provides some assistance, its accessibility is uneven across the NT, with many remote communities reporting insufficient teleconferencing setups or poor reception.[63] See Chapter 7 for a detailed discussion of telehealth. Lesley Woolf, Executive Health Manager from Mala'la Health Service in Maningrida stated:

> Just to put that in context, we have 30-odd outstations. Some are an hour-and-a-half to two hours away. The roads are very often cut. We have $120,000 per year to run that outstation service. That does not even fund one position. We provide services out there during the Dry Season, but there is not a lot of opportunity all year round. From a cultural perspective, if we would facilitate better services on the outstations, that would make a big difference.[64]

2.7 The Committee heard about major deficiencies in remote clinics and the need for patients to travel to receive care. A community leader in one remote community stated:

> [The local clinic] is very old. They build a clinic over at [a neighbouring community]—state of the art and all fabulous but no staff. So in the Dry Season we have the potential to go there to get renal treatment or whatever, but there is no staff. There are lots of reasons around that, but they are not classified as very remote so you do not get the extra money for nurses and doctors... The facilities [here] are so old that we do not have a room to have a palliative care space. It has only one toilet, and is only a treatment space.[65]

Cross-cultural challenges

2.8 The NT's residents are culturally and linguistically diverse. Aboriginal and Torres Strait Islander people make up more than 30 per cent of the Territory's population,[66] and there is significant language diversity with over 200 languages spoken.[67]

2.9 Aboriginal communities across the NT are diverse.[68] Whilst recognising that there is no single set of needs or views on VAD, it is important to note that Aboriginal and Torres Strait Islander people may face specific challenges in the context of a VAD service.[69] Approximately three quarters of Aboriginal Territorians live in rural or remote areas so they may be disproportionately affected by the challenges associated with remoteness.[70] Figure 3 shows remoteness across the NT. Some other potential challenges are set out below.

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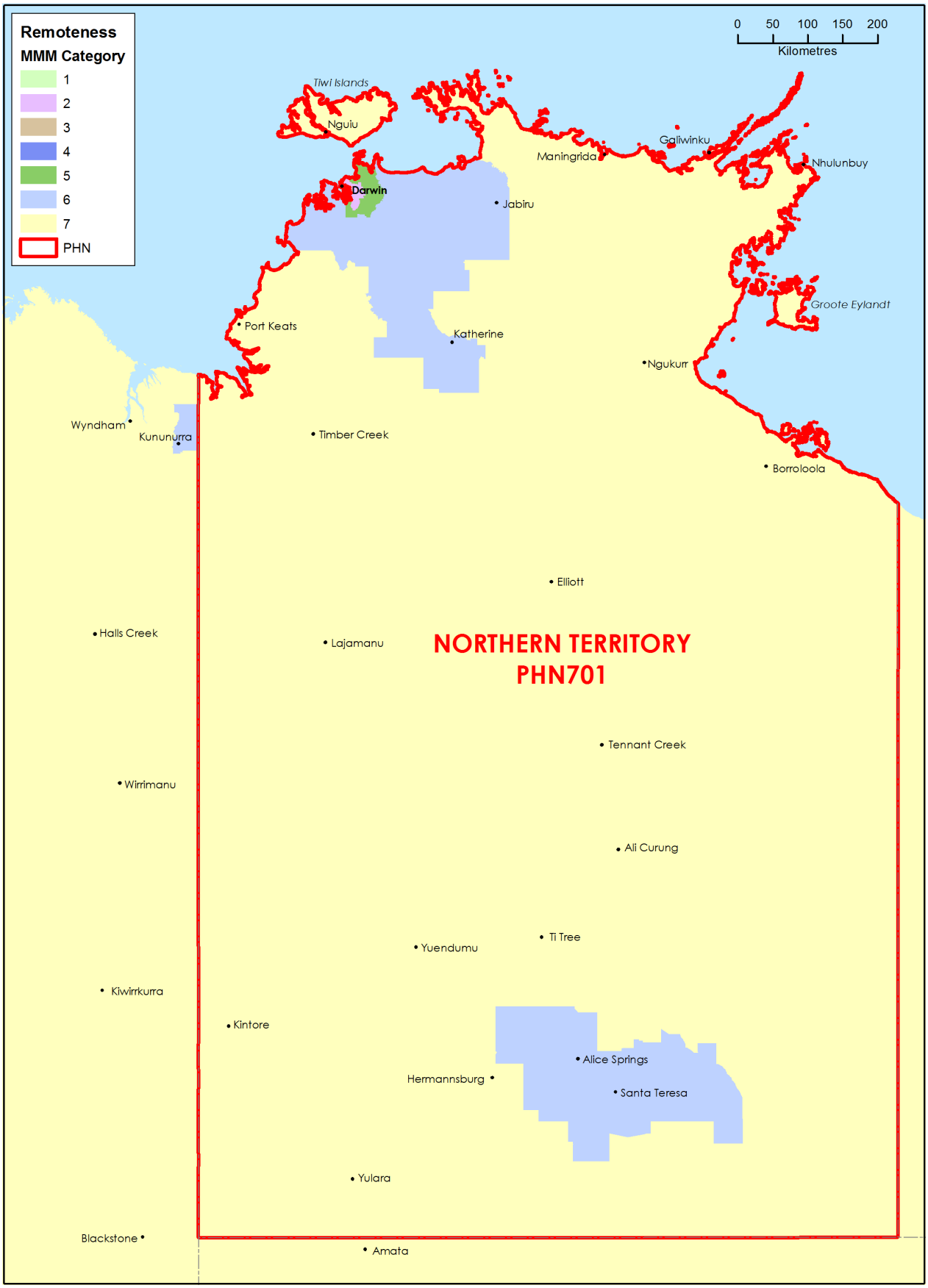
[61] NT Government, Department of Health, *Annual Report 2023-24*, p. 15.
[62] Meeting with community representatives of Maningrida, Darwin, 25 August 2025.
[63] Meeting with community representatives, Barunga, 12 August 2025.
[64] Meeting with community representatives of Maningrida, Darwin 25 August 2025.
[65] Meeting with remote community representatives, August 2025.
[66] Australian Institute of Health and Welfare, *Rural and remote health* (2024), https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health.
[67] NT Health, *Strategic Plan 2023-2028* (2023), p. 6.
[68] Aboriginal Medical Services Alliance NT, Public Hearing, Darwin 5 August 2025.
[69] NT Government, *Voluntary Assisted Dying Independent Expert Panel, Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 126-127.
[70] NT Government, Department of Health, *Annual Report 2023-24*, p. 16.

Figure 3: Levels of remoteness in the NT[71]



Intergenerational trauma and mistrust of health services

2.10 Some Aboriginal and Torres Strait Islander people and their families have had traumatic and difficult experiences with government and healthcare services in the past which may result in mistrust, fear and suspicion. Additionally, cumulative bereavements are a source of trauma and are likely to affect Aboriginal people's view of VAD.[72] Urapuntja Health Service Aboriginal Corporation stated their view about how mistrust of the healthcare system interacts with implementation of VAD:

> Trust in government systems is limited in many Aboriginal communities due to past traumas. This makes it essential that VAD is not imposed but discussed in ways led by community voices, with cultural humility and patience.[73]

2.11 Mistrust in health services is a major barrier facing Aboriginal and Torres Strait Islander Territorians.[74] The Committee heard that this lack of trust leads to incomplete care and a higher rate of people passing away.[75] Dr Penny Stewart, Head of Department at the Alice Springs Hospital, noted the flow on effects of this lack of trust:

> …people not taking those medical stories and doing the things that you need to do because they are not trusting the system and going, leads to incomplete care and a much higher rate of people passing.[76]

2.12 Health services reported a need for changes to the association of hospitals and clinics with death and trauma towards a greater emphasis on healing. [77] Many stakeholders to the Inquiry highlighted that this mistrust should be considered and factored into VAD service design to ensure its rollout is not harmful to Aboriginal and Torres Strait Islanders seeking care.[78] Patrick Torres, the Aboriginal Engagement and Strategy Unit's Cultural Coordinator at Alice Springs Hospital, explained how the healthcare system is trying to change the negative perception it holds for some people:

> …we are trying to change that way of thinking, you know. We are trying to advertise it and portray it as a healing centre not a hospital somewhere you come

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[71] Australian Government Department of Health and Aged Care, *Northern Territory (NT) Primary Health Network (PHN) map – Modified Monash Model (MMM) remoteness area* (2018), https://www.health.gov.au/sites/default/files/documents/2021/03/northern-territory-nt-primary-health-network-phn-map-modified-monash-model-mmm-remoteness-area-nt-phn-map-modified-monash-model-mmm-remoteness-area.png.

[72] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 126-127.

[73] Submission 22.

[74] Submissions 22, 25; Meetings with Alice Springs Hospital Palliative Care team and Aboriginal Engagement and Strategy Unit, Alice Springs, 21 August 2025 and community representatives of Maningrida, Darwin, 25 August 2025.

[75] Meeting with Alice Springs Hospital Aboriginal Engagement and Strategy Unit, Alice Springs, 21 August 2025.

[76] Meeting with Alice Springs Hospital Aboriginal Engagement and Strategy Unit, Alice Springs, 21 August 2025.

[77] Meeting with Alice Springs Hospital Aboriginal Engagement and Strategy Unit, Alice Springs, 21 August 2025.

[78] Submissions 22 and 25.

> to die... So that is what we're hoping to work towards but we have certainly got some hurdles to get there.[79]

2.13 In recent years, remote primary healthcare has transitioned from NT Health remote primary healthcare services towards ACCHSs.[80] ACCHSs are regarded as "best practice for community health", and a "world leading example of comprehensive primary healthcare, based on community control, a social view of health, multidisciplinary care, and an emphasis on accessibility and equity".[81] This is demonstrated in Figure 4 below. There are a number of advantages to this transition, including:

- ensuring culturally safe care;[82]
- providing holistic care that addresses inequity;[83]
- providing accountability to local communities;[84] and
- addressing remote workforce shortages and instability.[85]

2.14 Many stakeholders to the Inquiry noted the important role ACCHSs play in the provision of remote primary healthcare in the NT. Dr John Paterson, President of Aboriginal Land Councils and the Aboriginal Medical Services Alliance NT (AMSANT) stated:

> In terms of the future model of primary healthcare services in the Northern Territory, we want to work with those standalone communities. You would be well aware that there is a policy reform that is happening in the Northern Territory with transitioning Northern Territory Government-run clinics—those who want it— across to Aboriginal community control. We are looking at modelling them off successful models and regional health providers like Miwatj, Katherine West, Sunrise and Congress. The Aboriginal Congress in Alice Springs is in the process of transitioning a number of Northern Territory Government clinics under their auspices until those remote communities decide, at a cluster level, about whether they want to be incorporated and have their own health boards that make local decisions, as they see fit, for health and wellbeing services in their communities. We are trying, as best as we possibly can. This ain't going to happen overnight; this is a long process.[86]

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[79] Meeting with Alice Springs Hospital Aboriginal Engagement and Strategy Unit, Alice Springs, 21 August 2025.

[80] O. Pearson et al., 'Aboriginal community controlled health organisations address health equity through action on the social determinants of health of Aboriginal and Torres Strait Islander peoples in Australia' (2020), *BMC Public Health* 20(1859).

[81] T. Mackean et al., 'Leading the way: the contribution of Aboriginal community controlled health organisations to community health in Australia' (2025), *Australian Journal of Primary Health* 31, p. 1.

[82] Aboriginal Medical Services Alliance Northern Territory, *Pathways to Community Control* (2009), https://www.amsant.org.au/wp-content/uploads/2019/12/2009_Final_Pathways-to-Community-Control.pdf.

[83] T. Mackean et al., 'Leading the way: the contribution of Aboriginal community controlled health organisations to community health in Australia' (2025), *Australian Journal of Primary Health* 31, p. 1.

[84] J. Devitt et al., *The Northern Territory Aboriginal Health Forum: A Historical Review* (2015), T*he Lowitja Institute*.

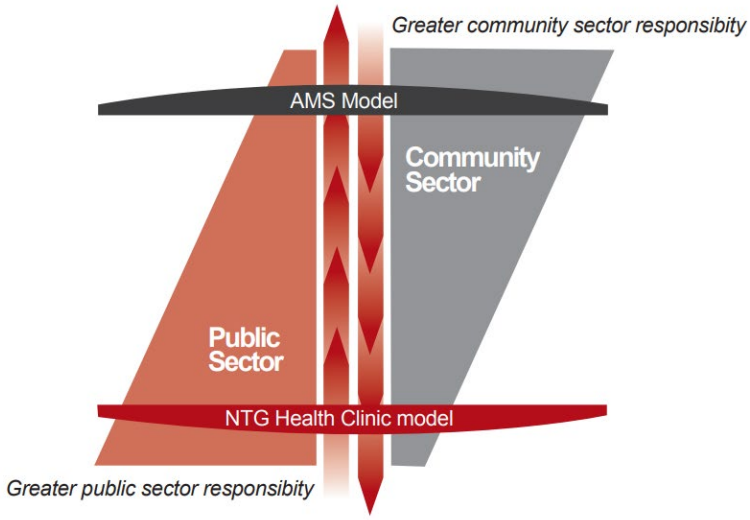
[85] J. Wakerman et al., 'Remote health workforce turnover and retention: what are the policy and practice priorities?' (2019), *Human Resources for Health*.

[86] Aboriginal Medical Services Alliance, Public Hearing, Darwin, 5 August 2025.

2.15 Central Australia Aboriginal Congress pointed to the important role ACCHSs might play in delivering VAD in the NT:

> VAD is a complex ethical, cultural and service delivery issue. ACCHSs need to be aware of their responsibilities under any proposed legislation, and be resourced to deal with the possibility that a community member may choose to access VAD and/or palliative care on Country and the cultural practices surrounding this.
>
> Ensuring culturally safe and clinically appropriate palliative care is available for all Aboriginal communities, especially in remote areas, is critical to allow Aboriginal people to exercise end of life choices on their own Country. ACCHSs are best placed to deliver such services should they so wish.[87]

Figure 4: Community Participation and Control[88]



Kinship-based decision-making

2.16 In many Aboriginal and Torres Strait Island cultures, medical decision-making is often done in kinship groups, rather than by the individual patient.[89] This issue is discussed in detail in Chapter 6 in relation to voluntariness.

2.17 Kinship decision-making is complex and diverse across communities and cultures.[90] A community leader of Ngukurr explained the importance of family in decision-making:

> I tell the doctor, 'I am going to speak to my families'. There is a procedure for us to talk to our families. I am not going to make that agreement or that story. I have to ask my husband, my family, my children and siblings. It is a family thing. I just tell them, 'I am going to speak to my family first and explain what is going to happen'.[91]

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[87] Submission 300.
[88] Aboriginal Medical Services Alliance Northern Territory, *Pathways to Community Control* (2009).
[89] Meetings with community representatives, Ngukurr, Borroloola, and Maningrida; Aboriginal Medical Services Alliance NT, Public Hearing, Darwin, 5 August 2025.
[90] Meetings with community representatives, Barunga, Borroloola, Ngukurr, Wurrumiyanga and Maningrida, August 2025.
[91] Meeting with St Matthew's Anglican Church, Ngukurr, 6 August 2025.

2.18 The Committee heard that sometimes Aboriginal and Torres Strait Islander people may face difficulties in involving their families in medical decision-making as it may conflict with medicalised approaches to healthcare.[92]

Language and cross-cultural communication barriers

2.19 Cross-cultural communication is a potential challenge to accessing safe and adequate healthcare.[93] This is discussed in detail in Chapter 7 in relation to the use of interpreters. English may be a second or third language for many Aboriginal and Torres Strait Islander people. The Committee heard of instances where limited interpreters were available to assist in remote communities. Additionally, many words do not translate directly into Aboriginal languages and there is the potential for miscommunication.[94] Dr Penny Stewart, Head of Department, Alice Springs Hospital, stated:

> …our Aboriginal workforce is key and actually ensuring their safety, ensuring better doctors better communication and listening to their voices is absolutely key to everything that we do. Because if you look at all of the problems around the hospital; like readmissions, take your own leave, lack of trust, it is all because of miscommunication and no relationship.[95]

2.20 A rare recent study of what NT Aboriginal people seek in their healthcare journey has been published, explored in the case study below. It resonates with the evidence the Committee received in remote communities.[96] The findings of the study set out in Figure 5, along with the Committee's report, may help inform the culturally safe design of NT VAD legislation and its implementation.

[92] Meeting with community representatives, Barunga, 12 August 2025.
[93] Submission 300; Meetings with Alice Springs Hospital Aboriginal Engagement and Strategy Unit, Alice Springs and community representatives, Borroloola and Maningrida, August 2025.
[94] Submission 300; Meetings with Alice Springs Hospital Aboriginal Engagement and Strategy Unit, Alice Springs and community representatives, Borroloola and Maningrida, August 2025; Aboriginal Medical Services Alliance NT, Public Hearing, Darwin, 5 August 2025.
[95] Meeting with Alice Springs Hospital Aboriginal Engagement and Strategy Unit, Alice Springs, 21 August 2025.
[96] E. B. Waugh et al.,., 'What do Aboriginal people in the Northern Territory value during the operation journey? A qualitative study', *Medical Journal of Australia* 233(1) (2025), p. 32.

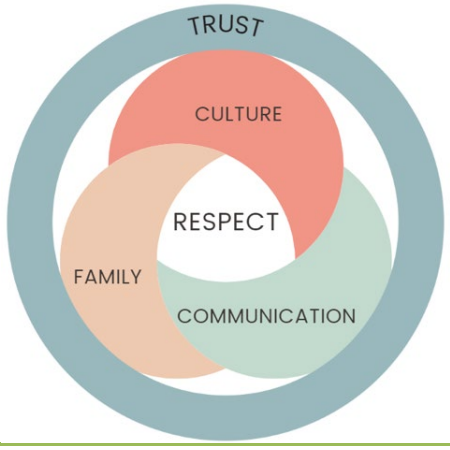
Case study: What do Aboriginal people in the Northern Territory value during the operation journey?

In July 2025, Dr Edith B. Waugh et al., published a study on the values of Aboriginal people in the NT during their operative journey,[97] finding:

- Respect emerged as the core principle in the perioperative journey, with family involvement, cultural practices and effective communication identified as key elements.
- Respect was evident in honouring cultural protocols, integrating traditional healing practices and recognising patient autonomy.
- Family involvement was highlighted as essential, with kinship ties influencing shared decision-making processes and support throughout the perioperative experience.
- Culturally competent communication, including the use of interpreters and clear explanations, played a critical role in bridging cultural differences and ensuring shared understanding.

Together, these elements fostered a sense of safety, belonging and empowerment. Ultimately, trust was identified as an overarching outcome that unified these interconnected values, enhancing patient comfort, engagement and overall satisfaction in the perioperative journey.

Figure 5: What do Aboriginal people seek in their healthcare journey



Different understandings of illness and dying

2.21 People may think about sickness, death and suffering differently depending on their cultural background. Death and dying may be a taboo to speak about due to superstitions or mistrust.[98] The Committee heard in some contexts that having

[97] E. B. Waugh et al., 'What do Aboriginal people in the Northern Territory value during the operation journey? A qualitative study', *Medical Journal of Australia* 233(1) (2025).

[98] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), pp. 126-127.

conversations about death may cause concerns about "cursing", "bad luck" or "black magic".[99] In Borroloola, Christine Anderson, Manager of Malandari Aged Care, highlighted the sensitivities of discussing death and dying with clients and families:

> Yes, some people, if I asked them a question about dying towards the end of life, and they will say, 'Why talk like that to me? You're giving me bad luck.' So you have to be really careful what you say, so we just look after them and the family come in and look after them.[100]

Burden of disease

2.22 The NT's small and widely dispersed population has the highest burden of disease of any Australian jurisdiction, with Aboriginal and Torres Strait Islander people carrying a higher burden of disease rate than non-Aboriginal and Torres Strait Islander populations.[101] NT Health state that contributing factors to this are "high rates of social disadvantage, poverty and low levels of health literacy".[102] Other factors include "geographic isolation and remoteness, inadequate infrastructure and resources, the complex needs of the large proportion of Indigenous Australians, and the difficulty of recruiting and retaining health care workers".[103]

2.23 The impact of this is that Aboriginal people in the NT's life expectancy at birth is about 15 years shorter than for non-Aboriginal NT residents, and life expectancy at birth is lower in the NT than in all other states and territories.[104] This intersects with VAD as "cumulative bereavements in Aboriginal or Torres Strait Islander families are a source of trauma and are likely to affect people's response to [VAD]."[105] In Ngukurr, a community leader explained:

> Mainly the diseases in communities are kidney failure, cancer and heart. They are the main three. We know already people are not healthy. We already know that. We try and encourage family to go to the clinic, but they say they have never been to that clinic. This is the truth that I am saying, and we cannot change them and stay this issue. But what we do culturally is to surround them and give them the love they need from us.[106]

Health workforce shortages

2.24 The NT healthcare system faces "significant workforce shortages",[107] particularly in mental health, rehabilitation, oral health, alcohol and drug services, and health

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[99] Meetings with Mabunji Aboriginal Resource Indigenous Corporation, Borroloola, 7 August 2025 and community representatives of Maningrida, Dawin, 25 August 2025.
[100] Meeting with Mabunji Aboriginal Resource Indigenous Corporation, Borroloola, 7 August 2025.
[101] NT Health, *Morbidity burden of disease and injury in the Northern Territory 2014–2018* (2014), pp. 14-15.
[102] Northern Territory Government, Department of Health, *Aboriginal and Torres Strait Islander health*, https://health.nt.gov.au/professionals/aboriginal-and-torres-strait-islander-health.
[103] D. Upton and V. Ruwanpura, 'A Northern Territory-trained health workforce is required to meet its context-specific disease burden and health care needs' (2024), *Medical Journal of Australia* 221(11).
[104] Y. Zhao et al., 'Assessing the adequacy and sustainability of the Northern Territory health workforce with respect to burden of disease and injury, 2009–2021: an analysis of administrative data' (2024), *Medical Journal of Australia* 221(11).
[105] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 126.
[106] Meeting with St Matthew's Anglican Church, Ngukurr, 6 August 2025.
[107] Submission 368.

promotion. Critical gaps exist in nursing, midwifery, GPs, chronic disease care, dental services, and Aboriginal health practitioners.[108] High turnover, especially in remote areas, undermines trust and continuity of care, contributing to health inequalities.[109]

2.25 The NT health workforce is estimated to be 22 per cent smaller than needed, creating unsustainable pressure, burnout, and stress.[110] Remote health workers face additional challenges, including isolation, limited resources, and complex care needs, leading to high stress, short-term contracts, and a cycle of workforce instability. [111]

2.26 In remote communities, the Committee heard varied experiences of workforce shortages and healthcare retention. Whilst few communities reported adequate staffing,[112] more communities noted there was a need for more healthcare workers. The Committee heard that high staff turnover impacts trust in local clinics, as people are unable to build relationships with clinical staff.[113] In Papunya, the Committee heard:

> …agency nurses who just come in six weeks at a time. They cannot build a relationship in the community because they are only here for six weeks and are gone, then a new lot come in for another six weeks.[114]

Interface with existing health services

2.27 Implementation of a VAD framework intersects with existing healthcare services, including palliative care, aged care, disability support, mental health services and Aboriginal health services. Understanding these interactions is critical to ensuring that the VAD framework is safe, culturally appropriate and integrated within the NT's unique healthcare framework. Palliative care is discussed in detail in Chapter 3.

Aged care services

2.28 Across jurisdictions, most people seeking VAD are aged 70–79 and have terminal cancer, [115] with around 10% living in aged care facilities. [116] After private homes and hospitals, aged care facilities are the third most common setting where VAD is administered. In the NT, aged care is primarily funded by the Australian

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[108] Northern Territory Primary Health Network, *Health Workforce Needs Assessment 2024* (2025), https://ntphn.org.au/wp-content/uploads/2025/04/Health-Workforce-Needs-Assessment-2024.pdf.
[109] D. Upton and V. Ruwanpura, 'A Northern Territory-trained health workforce is required to meet its context-specific disease burden and health care needs' (2024), *Medical Journal of Australia* 221(11).
[110] Y. Zhao et al., 'Assessing the adequacy and sustainability of the Northern Territory health workforce with respect to burden of disease and injury, 2009–2021: an analysis of administrative data' (2024), *Medical Journal of Australia* 221(11).
[111] D. Upton and V. Ruwanpura, 'A Northern Territory-trained health workforce is required to meet its context-specific disease burden and health care needs' (2024), *Medical Journal of Australia* 221(11).
[112] Meeting with community representatives of Maningrida, Darwin, 25 August 2025.
[113] Meeting with community representatives, Papunya, 20 August 2025.
[114] Meeting with community representatives, Papunya, 20 August 2025.
[115] Go Gentle Australia, *State of VAD Report 2024* (2024).
[116] SA is an exception in this regard.

Government,[117] but funding per person is lower than the national average.[118] Residential and flexible aged care services account for the largest portion of expenditure.

2.29 Many facilities are run by faith-based organisations, some of which do not support VAD, creating barriers for residents who wish to access it. Throughout the Inquiry, the Committee visited a number of aged care facilities to meet with staff and residents. Whilst the Committee met with some facilities that indicated they would conscientiously object to VAD,[119] the Committee also met with residents that supported their rights to choose VAD.[120]

2.30 Access to aged care varies widely, with full-time medical staff mostly concentrated in urban centres, while remote areas rely heavily on family and friends providing informal care with minimal government support.[121] As staff at the Julalikari Council Aboriginal Corporation explained:

> There are a lot of people, and my understanding is that family and friends effectively support for free and that is the same in the disability space. So, people will be getting care that just is not recognised or it is not in an institutional setting.[122]

2.31 In the NT most of the community-based services in aged care, including remote areas, are provided by Local Councils. These community-based services are often stretched, with limited staff, long travel distances, and clinics that may be inaccessible or closed. This fragmented system complicates end-of-life care and raises challenges for ensuring equitable access to VAD, especially for people in remote communities. In one remote community an aged care worker described the typical setting in which she delivers aged care services to Home Care Patients including personal care, in-service meals and laundry services:

> There is normally like 20 people, or more than 20 people who live in one house. All the family is looking after the client, but it is really hard to bring him to the clinic. There is no GP and only allied health, and you need to wait a long time. He cannot move properly, so it is hard for the family to bring him. Sometimes they go there and the clinic is closed and they have to come back. It is difficult for them.[123]

2.32 Between intensive residential aged care and home support, some remote NT facilities offer beds with limited clinical support rather than full-time nursing care. Respite day services provide short-term relief, offering clients meals, showers, and a safe space,

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[117] Productivity Commission, *Report on Government Services 2025* (January 2025), Section 14: Aged care services.

[118] The Australian Government's aged care average annual expenditure per person aged 50 years or over (Aboriginal and Torres Strait Islander) and aged 65 years or over (non-Indigenous) in the NT is $6,527, below the Australian average of $7,452. See Productivity Commission, *Report on Government Services 2025* (2025), Section 14: Aged care services.

[119] For example, Meetings with staff at Pulkapulkka Kari Flexible Aged Care and Tennant Creek Local Authority Tennant Creek, 27 August 2025.

[120] Meeting with staff and residents, Old Timers Aged Care, Alice Springs, 21 August 2025.

[121] Meeting with Julalikari Council Aboriginal Corporation, Tennant Creek, 28 August 2025.

[122] Meeting with Julalikari Council Aboriginal Corporation, Tennant Creek, 28 August 2025.

[123] Meeting in a remote community, August 2025.

especially for those living in difficult conditions. However, these services do not provide palliative care or medication.[124]

Figure 6: The Committee with Julalikari Council Aboriginal Corporation, Tennant Creek

Mental health services

2.33 There is a strong interaction between end-of-life care and mental health services. They provide psychological care to individuals considering VAD, assess decision-making capacity, and bereavement support families and carers before, during, and after the process. These services also help train and debrief health workers involved

[124] Meeting with Julalikari Council Aboriginal Corporation, Tennant Creek, 28 August 2025.

in end-of-life care and contribute to policy, governance, and research to ensure high standards of care.[125]

2.34 Throughout the Inquiry, the Committee heard from a range of mental health services.[126] The Committee was told that mental health system in the NT is already under significant strain, especially in rural and remote areas where services are scarce or non-existent. In many communities, there are no clear referral pathways, leaving families to cope alone during crises such as suicide. Bereavement services are also lacking, leaving people without support after sudden or traumatic deaths.[127] For example, Jacqueline Bethel, Chief Executive Officer (CEO) of Tennant Creek Mob Aboriginal Corporation, explained:

> The suicide prevention project [delivered by The Tennant Creek Mob Aboriginal Corporation] is about training up first responders in communities to deal with suicides that happen on site. We have very limited mental health services in the region. The referral pathways into services just aren't there in remote areas. What this project is about is training up community members in Mental Health First Aid so they can act as first responders in emergencies.
>
> A lot of the communities in the region do not have permanent police, so when somebody commits suicide it is often the families that have to deal with it.[128]

2.35 The shortage of bereavement services was highlighted Dr Chris Anderson, Specialist Doctor Palliative Care at Alice Springs Hospital:

> We don't have a bereavement service here, we do not have a bereavement service for our existing clients. We did but when the unit got set up, the position kind of went away and I think that is something I could identify as a resource that is going to be needed across the board for our community. Not just for palliative care and VAD patients but also deaths, traumatic deaths people who have had terrible things happen and they have died in the hospital somewhere. There is a lot and dying in this community and not enough bereavement services.[129]

2.36 Access to mental healthcare in the Territory is well below the national average, with far fewer residents receiving federally subsidised or specialist services.[130] In the NT, 2.9 per cent of the population received Territory Government specialised mental health services, compared to the Australian average of 1.9 per cent. This under-resourcing makes it difficult to meet current needs, let alone the additional demands that VAD would bring. Many stakeholders to the Inquiry pointed to the need for greater funding for mental health services.[131]

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[125] Submission 168.
[126] Submissions 25, 159.
[127] Meeting with Alice Springs Hospital Palliative Care team, Alice Springs, 21 August 2025.
[128] Meeting with Tennant Creek Mob Aboriginal Corporation, Tennant Creek, 28 August 2025.
[129] Meeting with Alice Springs Hospital Palliative Care team, Alice Springs, 21 August 2025.
[130] Productivity Commission, *Report on Government Services 2025* (February 2025), Section 13: Services for Mental Health.
[131] See for example, Submissions 67, 90.

Disability services

2.37 In 2021, 8,308 people with disabilities (i.e., requiring assistance with core activities) lived in the NT.[132] As of June 2025, 6,537 people in the NT are benefiting from the National Disability Insurance Scheme.[133] Aboriginal Australians are 1.9 times more likely to have a disability than non-Aboriginal Australians. Forty-three per cent of Aboriginal Territorians with disabilities live in remote areas.[134] Disability services in the NT are facilitated similarly to aged care services through a mix of residential facilities and community-based non-residential services. Informal support provided by family and friends is paramount.

2.38 There is limited data on people with a disabilities accessing VAD in Australia. Currently, only one jurisdiction, New South Wales (NSW), reports annually on the number of people accessing VAD from within residential disability care facilities.[135] This lack of data makes it difficult to fully understand the needs and experiences of people with disability in relation to end-of-life choices.

2.39 It is clear, however, from the evidence the Committee has received that people with a disability want to be able to access VAD (Figure 7). This is discussed further in Chapter 6 of this Report. As NT resident, Mr Kevin Hubble, explained:

> During the course of the last few weeks I have found out I have a serious condition, Parkinson's Disease, which will affect my quality of life. While I supported the concept of VAD previously, this diagnosis has bought the issue into sharp relief and I feel I need to contribute to this discussion.
>
> I feel the terms laid out in the [Committee's] consultation paper are too narrow, and would not allow the relief of suffering for a number of people, including myself. The requirement that the person should have a terminal disease that will kill them in the next 6 to 12 months leaves out many who will suffer, sometimes for decades, with severe disability, because they are not likely to die in the next 12 months.
>
> My own prognosis is that I will live to an average age, so no reduction in life span, but severe negative changes to my quality of life. I am likely to have manageable symptoms for 10 to 20 years then, over a period of 5 to 10 years I will decline rapidly, with loss of mobility, loss of continence and probably dementia. Under the current suggested rules I would not be eligible to access VAD, despite what could be a complete loss of quality of life. I would like to see the laws cover these situations. Have a way of determining quality of life and be able to specify at what point in that continuum I would like to end my suffering.[136]

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[132] Australian Bureau of Statistics, *Disability and carers: Census, 2021* (2022) https://www.abs.gov.au/statistics/health/disability/disability-and-carers-census/latest-release.
[133] National Disability Insurance Scheme, *Northern Territory* (2025), https://www.ndis.gov.au/understanding/ndis-each-state/northern-territory.
[134] Australian Institute of Health and Welfare & National Indigenous Australians Agency, *Measure 1.14 Disability* (2023), https://www.indigenoushpf.gov.au/measures/1-14-disability.
[135] NSW Voluntary Assisted Dying Board, *Annual Report 2023–24* (2024).
[136] Submission 183.

Figure 7: Community consultation in Tennant Creek with Amy James, disability advocate and representative on the National Living with Disability Advisory Board and Alba Brockie, disability advocate

Aboriginal medicine, beliefs and practices

2.40 Stakeholders to the Inquiry emphasised the need for Western healthcare to acknowledge and integrate traditional Aboriginal healing practices in the design and delivery of any VAD service in the NT. Some aged and palliative care facilities already provide culturally safe care by creating spaces that respect cultural traditions, such as allowing families to gather freely, perform ceremonies, and use bush medicines alongside clinical treatment. Nursing staff at Pulkapulkka Kari Flexible Aged Care, Tennant Creek described how the facility at Nhulunbuy that provides renal services and palliative care successfully incorporates both:

> There is plenty of room there. Families can come and go; there are no restrictions. It leads to outdoors where they can actually enjoy themselves, get some fresh air and everything. Even if you are dying, why can we not push your bed outside and get some sunlight—things like that… it is a neutral space and it will allow families to do whatever they want. If they want to do a smoking ceremony… they are allowed… Bush meds—medications they have grown up with [can be used]… I think that is strong because they stay cultural…
>
> Smoking ceremonies, now we have got to wait by the fire alarm. We cannot do it where they want to because we have got to organise for Chubb to come from Alice Springs to come to isolate it, whereas if they were separate it would be easier

> to do that. We do not have to worry about all those things if they want to do the smoking ceremony; whatever makes them happy.[137]

2.41 Staff also highlighted the importance of supporting traditional medicine use on-site and noted that spiritual beliefs, such as witchcraft, often coexist with Western medical practices. This demonstrates the need for flexibility and respect in care models to meet diverse cultural needs. A witness in a remote community described:

> When I was a health worker we had the old clinic over here, next to this... I was a health worker; I was a trainee health worker. One of my cousin-brothers, his brother-in-law cut him with a stubby bottle. He broke that stubby bottle and cut him on the side. I witnessed this. When the nurse treated that wound, I had seen a grass—there were bushes, grass, coming out of that wound. I knew it was witchcraft... That is the first time I had seen it, but I was a health worker. It does happen, I think, all the time.[138]

Committee comments

2.42 The Committee acknowledges that the NT faces unique and complex challenges in healthcare delivery, shaped by remoteness, cultural diversity, and workforce shortages. The Committee notes that VAD will intersect across palliative care, aged care, mental health services, disability support and Aboriginal health services, and understanding existing challenges in these sectors is important.

2.43 These issues will not be resolved immediately and will continue to shape the way VAD may be implemented in the NT. Any VAD service must be designed to operate effectively within these existing limitations, whilst remaining adaptable to future changes to the healthcare system and infrastructure.

2.44 The subsequent Chapters of this Report set out recommendations for how a VAD model can be developed to meet the unique needs of the NT.

[137] Meeting with Pulkapulkka Kari Flexible Aged Care staff, Tennant Creek, 27 August 2025.
[138] Meeting with community representatives, Barunga, 12 August 2025.

3 Finishing up well: End-of-life choices

Overview

3.1 There are many different ideas of what 'finishing up well' or having a 'good death' mean. These ideas may inform the choices a person makes at the end of their life. A person may have many options in their end-of-life care, including continuing treatment for their illness, palliative care and pain management, or withdrawing from medical treatment. End-of-life choices do not exist in isolation, and they may overlap or change over time.[139] VAD can sit alongside, interact with, and complement these other choices.

3.2 The 2024 Expert Panel Report recognised the importance of palliative care services in the NT and discussed how VAD might interact with other end-of-life choices.[140] It recommended that:

- A person who requests VAD must be informed of all treatment options including the nature, scope and availability of palliative care services.
- Further resources should be provided to educate the community about the nature and scope of palliative care options, particularly for people who wish to remain at home.
- Palliative care services must be consistently and adequately resourced to provide specialised and holistic palliative care to patients, wherever they live in the NT and to address the gaps in those services that result in inequities in people's end-of-life options. Implementation of VAD services in the NT must be complementary to, not at the expense of, expanded palliative care resources.[141]

3.3 The Committee supports Recommendation 7 of the 2024 Expert Panel Report.

3.4 This Chapter discusses different perspectives on what it means to finish up well and explores the end-of-life choices available in the NT context, including palliative care, withholding or withdrawing life sustaining treatment, and continuing treatment in order to contextualise VAD as another end-of-life choice.

What it means to 'finish up well'

3.5 Throughout the Inquiry, the Committee heard Territorians wanted "help and choice to finish up well".[142] 'Finishing up well' or having a 'good death' mean different things to different people.[143] The Committee heard about a shared desire for the following factors at the end of a person's life:

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[139] Meeting with community representatives of Maningrida, Darwin, 25 August 2025.
[140] NT Government, *Voluntary Assisted Dying Independent Expert Panel, Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), Recommendation 7.
[141] NT Government, *Voluntary Assisted Dying Independent Expert Panel, Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), Recommendation 7.
[142] Meeting with the community representatives, Borroloola, 7 August 2025.
[143] E. Meier, et al., 'Defining a Good Death (Successful Dying): Literature Review and a Call for Research and Public Dialogue', *American Journal of Geriatric Psychiatry* 24(4) (2016).

- dignity;[144]
- comfort;[145]
- presence of family and friends;[146] and
- ability to perform religious or cultural practices.[147]

3.6 This section outlines some of the different perspectives the Committee heard across the NT.

Medical treatment and pain relief

3.7 Some Territorians expressed a medicalised understanding of what a good death entails. This could include continuing medical treatment or receiving pain management to ease their suffering.[148] Lesley Woolf, Executive Health Manager from Mala'la Health Service in Maningrida, outlined how Mala'la can help with pain relief at home or in aged care to make sure people are as comfortable as possible:

> People have the choice to stay at home or, if they would like to be in aged care we can facilitate that—wherever we can, we do. If people prefer to die at home or be at home, that is fine. The nursing staff from the clinic will go and visit them every day, sometimes twice a day, and provide pain relief, whatever needs to happen.
>
> Because we have staff on duty 24 hours a day there is always somebody available from the clinic should a patient require pain relief or some assistance. If they move into aged care, we have an area where they can be. We allow the family to all be there if they want to be. We have built what we call a quiet room, but it is a room where family can sit. We make sure they have tea and coffee; they can make that themselves—all that sort of thing. We facilitate pain relief and ensure that is happening and that their journey is as culturally appropriate, but as comfortable as possible.[149]

3.8 Irene Snell, Service Manager at Pulkapulkka Aged Care explained that some people will choose to continue treatment right up until the end of their life:

> They [doctors] pump them with medications. People tend to prolong life, even though we all know that it is actually not working. I personally feel that if you have got comorbidities, just to be comfortable. Why are we pumping you with cardio meds if you are not going to monitor your cardio status, if we are not going to do anything about it? Why are you pumping them with this? There has got to be a rationale why we are giving you the things, but people want it and that is their choice for them. They want the medications. Whether there is a rationale or not they do not care, but the doctor must prescribe something.[150]

3.9 In some instances, the Committee heard that people may have a medicalised understanding of a good death, but they were unable to receive adequate care. In one

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[144] Submission 84.
[145] Submission 5; Meeting with Pulkapulkka Kari Flexible Aged Care staff, Tennant Creek, 27 August 2025.
[146] Meetings with Mabunji Aboriginal Resource Indigenous Corporation, Borroloola, 7 August 2025 and community representatives, Barunga, 12 August 2025.
[147] Meetings with Mabunji Aboriginal Resource Indigenous Corporation, Borroloola, 7 August 2025 and community representatives, Barunga, 12 August 2025.
[148] Meeting with community representatives, Barunga, 12 August 2025.
[149] Meeting with community representatives of Maningrida, Darwin, 25 August 2025.
[150] Meeting with Pulkapulkka Kari Flexible Aged Care, Tennant Creek, 27 August 2025.

community, a resident stated: "We are not close to town. A lot of people suffer here, they do not get assistance".[151]

A 'natural death'

3.10 The Committee heard many Territorians' preference for a 'natural death'. This may mean that a person chooses not to have any medical intervention, including choosing not to have treatment or pain relief. These perspectives were often informed by cultural and/or religious beliefs around death and dying.

3.11 In remote communities, the Committee heard that many Aboriginal people would prefer a natural death due to cultural beliefs.[152] Brian Hume, a Director of Mabunji Aboriginal Resource Indigenous Corporation in Borroloola stated: "Culturally, they prefer to pass away naturally".[153]

3.12 Some stakeholders explained that, for them, there was a preference to feel rather than mask pain at end-of-life. In Barunga, the Committee heard that Aboriginal people may want to die naturally, even if this means they are in pain:

> …Aboriginal people we have the belief that we should finish on our own, like even if we are suffering and in so much pain, this is part of life for us.[154]

3.13 A Barunga Elder further explained to the Committee via a Kriol interpreter:

> At least when they die they cannot feel pain no more. We want them to finish on their own, not with—we never had this in our life before, so it is hard for us to adapt to this kind of stuff. When we know our family is going to finish, all the family get together. They go to the house where that person lives.
>
> Everyday there is more family coming because we have family spread out all over the countryside in different communities and it gives the families time to come in from other communities to say their last goodbye to them. They just sit with them until they are ready to finish on their own.[155]

3.14 A community member in Numbulwur said that Aboriginal people may choose not to have doctors involved when they get sick:

> They want them to stay like that and die in their place by their own will… in Aboriginal law they do not like doctors treating our people. We want them to die naturally… Imagine if that person gets really sick, the doctor comes up to the house and there is a lot of family in the house. When they see the doctor they will ask, 'Why did you come?' The Aboriginal people do not like doctors coming and treating our family. We would rather die naturally on our own.[156]

3.15 Other stakeholders to the Inquiry noted that a good death would be natural, noting fears of distorting mental capacity through pain relief.[157]

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[151] Meeting with community representatives, Barunga, 12 August 2025.
[152] Meetings with Mabunji Aboriginal Resource Indigenous Corporation, Borroloola, 7 August 2025 and Alice Springs Hospital Aboriginal Engagement and Strategy Unit, 21 August 2025.
[153] Meeting with Mabunji Aboriginal Resource Indigenous Corporation, Borroloola, 7 August 2025.
[154] Meeting with community representatives, Barunga, 12 August 2025.
[155] Meeting with community representatives, Barunga, 12 August 2025.
[156] Meeting with community representatives, Numbulwar, 26 August 2025.
[157] Submission 23.

Finishing up on Country

3.16 The importance for many Aboriginal and Torres Strait Islander people returning to Country at the end of life is well established and widely recognised.[158] One of the most consistent themes the Committee heard during remote community consultations was the desire of Aboriginal people to return to Country to finish up there. The idea of 'Country' has been described as:

> ...the lands, waterways and seas to which they are connected. The term contains complex ideas about law, place, custom, language, spiritual belief, cultural practice, material sustenance, family and identity.[159]

3.17 Research undertaken in the NT has found many reasons why Aboriginal people wish to die on Country including:

> ...strong connection with land and community, a belief in 'death country', the importance of passing on sacred knowledge to the appropriate family member, the significance of ensuring that the dying individual's 'animal spirit' is able to return to the land, and the imperative that the 'right person' in the family network is available to provide the care.[160]

3.18 In Barunga, the Committee heard about the associated spiritual beliefs of returning to Country:

> In our culture too, when they are ready to die their spirit—we are very spiritual people. When they die, their spirit goes back to their country. That is another reason why we do not like the intervention with their death. It is a hard subject to talk about because we are spiritual people and it is hard to explain.[161]

3.19 Christine Anderson, Manager of Malandari Aged Care in Borroloola, noted the importance of being able to fulfil cultural practices and having family surrounding the person who is dying:

> When someone is dying, there is a lot of family in the room with them too, all the time. Then at the end... you talk about the junggayi, and then we leave, and it is up to them what they do—smoking and all that. And he is in charge of that, in charge of everything and all their things in the room... Most of them just want to come home to Country and be looked after by family, and just to pass away here with family all around them. That is what most of them want.
>
> ...you get the older ladies, they will go in and sing, clap... Yes, and it is really nice, listening to that. And they just lie there. [A community member] and them used to come up and sing to certain individuals. It is just good, that person just lays there, because they can hear and everything and just listen.[162]

3.20 Charlie Gunabarra, Chairperson Representing Maningrida, Mala'la Health Service similarly highlighted the importance of family and cultural practice:

> If someone, say, from the community, has hundreds of [family members]here in Darwin. When that person is unwell, what they do is they send the person back

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[158] End of Life Directions for Aged Care, *Aboriginal and Torres Strait Islander Peoples* (2025), https://www.eldac.com.au/Our-Products/Our-Diversity/Aboriginal-and-Torres-Strait-Islander-Peoples.
[159] Australian Institute of Aboriginal and Torres Strait Islander Studies, *Welcome to Country* (2025), https://aiatsis.gov.au/explore/welcome-country.
[160] P. McGrath, "I don't want to be in that big city; this is my country here': research findings on Aboriginal peoples' preference to die at home', *Australian Journal of Rural Medicine* 15(4) (2007).
[161] Meeting with community representatives, Barunga, 12 August 2025.
[162] Meetings with Mabunji Aboriginal Resource Indigenous Corporation, Borroloola, 7 August 2025.

> home or they do the teleconference with family back home. Staying with us we've got whole family, you know. The doctors with the information, he comes over home and just talks to family. He says, 'We will probably watch him and it will be a couple of days'. People will understand.
>
> Before it was really hard. We kept them, and there was a lot of drama from family—argument—but now everybody understand that when families—basically they need to go back and settle it with all the family, and they make a plan, if this person is going to pass away we're going to send them back home. That is where he belong, homeland. They do a lot of ceremony, dancing, you know… Extended family is probably out of community, flying in for sorry business. We give them time, and then the day we have the funeral.[163]

3.21 At Old Timers Aged Care Service (Figure 8), a facility run by Australian Regional and Remote Community Services (ARRCS), Michael Coughwan, Executive Manager, First Nations Programs explained:

> A client might want to have 32 days of leave, able to leave the facility… they might use those to go back for sorry business, but in this case they might want to go back to pass away, around family, on Country, somewhere familiar and comfortable. A lot of people [want to die] on Country in the first place to a facility, and the community does not want to let them go as well because in many cases they do not get home. Having a return to country service and that ability to take them back helps them… What we provide in order to make that happen, make sure there is a wraparound care service so that everything they are getting here is provided by family or a service in the community.[164]

[163] Meeting with community representatives of Maningrida, Darwin, 25 August 2025.
[164] Meeting with staff and residents, Old Timers Aged Care, Alice Springs, 21 August 2025.

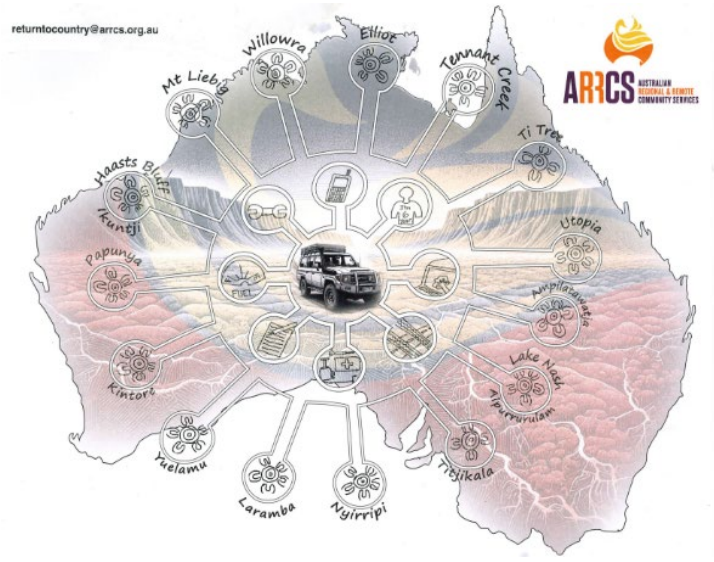
Case study: Visiting Country program at Pulkapulkka Kari Flexible Aged Care

The Committee heard about the initiative of Pulkapulkka Kari Flexible Aged Care (Tennant Creek), to fulfil the final wishes of residents to visit Country before they die. Staff explained that a day trip was organised recently to Elliot for a resident with the family throwing a party. The resident then returned to the aged care facility and passed away. Similar trips have been organised for clients to Ali Curung and Alice Springs.[165]

These opportunities fall outside the eligibility parameters of another valuable service - Return to Country run by ARRCS. The Visiting Country service provides support to elderly Aboriginal and Torres Strait people in regional centres as well as remote areas to reconnect with family, community and culture.[166] It is funded in part by the Commonwealth Home Support Programme (CHSP) and ARRCS's general revenue. The approach:

> ...is embedded in a framework of deep respect for cultural care, kinship, country, cultural traditions, cultural beliefs and cultural activities. There are occasions where we already provide full wrap around supports to elders dying (where they are aware they are dying) in our facilities or where they return home (return to country for other purposes).[167]

CHSP funding cannot be used for people with intensive, multiple or complex needs, or permanent residents of aged care facilities. A VAD Return to Country service would require additional funding according to the agency.[168]



[165] Meeting with Pulkapulkka Kari Flexible Aged Care staff, Tennant Creek, 27 August 2025.
[166] Australian Regional and Remote Community Services, *Visits to Country*, (2025), https://www.arrcs.org.au/services/out-and-about/visits-to-country.
[167] Meeting with Pulkapulkka Kari Flexible Aged Care staff, Tennant Creek, 27 August 2025.
[168] Submission 381.

Figure 8: Community consultation at the Old Timers Home, Alice Springs

End-of-life choices

3.22 VAD is one of many end-of-life choices. A person may pursue multiple end-of-life options at the same time, or their choices might change over time. Lesley Woolf, Executive Health Manager from Mala'la Health Service in Maningrida noted that a person may change their mind about their end-of-life decisions at any time:

> The doctor puts it to the patient, but it is their decision. They can say, 'No, I do not want that'. People also know that they can change their mind today. It is not set in concrete. When it is explained to people, as long as they understand what is being said and certainly… we use family to interpret, they know they can change their mind. They might say today that they do not want further treatment but tomorrow, 'Yes, please. Send me into Darwin. I want as much treatment as possible.' That is perfectly okay. It is really their decision. People have to feel confident with that.[169]

Palliative care

3.23 Palliative care helps people live their life as fully and comfortably as possible when living with a life-limiting illness.[170] The Commonwealth Department of Health, Disability and Ageing states:

> Palliative care is based on individual needs and may involve:

[169] Meeting with community representatives of Maningrida, Darwin, 25 August 2025.
[170] Submission 153.

- relief from pain and other physical symptoms
- planning for future medical treatment decisions and goals for care
- emotional, spiritual and psychological support
- help for families to come together to talk about sensitive issues
- support for people to meet cultural obligations
- counselling and grief support
- referrals to respite care services.[171]

3.24 Palliative care services in the NT are provided via a mixture of residential facilities, community-based services and in-home support.[172] All jurisdictions except the NT have developed a palliative care or end-of-life framework to underpin their services in accordance with the *National Palliative Care Strategy*.[173] Palliative Care Australia stated:

> PCA would encourage the NT to work with its non-government palliative care sector, including Palliative Care Northern Territory, to develop and articulate how it will provide these services to its citizens.[174]

3.25 A key theme that emerged in the Inquiry was the inequity in access to palliative care across the NT. The Committee was advised by several sources that palliative care services in the NT are patchy and limited to key urban centres.[175] As Palliative Care NT explained:

> There are massive gaps in the hands-on care services that are available in the community – and huge areas of the Territory are simply black holes in terms of access to supports. People living outside Darwin and Alice, especially in remote communities, have limited access to specialist palliative care, and people frequently end up dying in hospitals and palliative care facilities that are not where they want to be because it is not possible to get them home.[176]

3.26 Similarly, Dr Kane Vellar, former Expert Panel member and Clinical Subject Matter Expert at NT Health advised that:

> We do know that [palliative care] is woefully insufficient at present and does need attention. It has been an issue that, from a personal perspective as well as working in that area that we see an urgent need for that. However, there are always budgetary constraints and conflicting priorities which mean that it is difficult often for everybody to be satisfied with what is only a finite slice of the pie available to fund these services.[177]

3.27 The shortage of palliative care services in remote communities was raised with the Committee at most of the other community engagements it held. In Ngukurr, the Committee was told by Reverend Majorie Hall, St Matthew's Anglican Church:

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[171] Australian Government, *What is palliative care?* (2025), https://www.health.gov.au/topics/palliative-care/about-palliative-care/what-is-palliative-care.
[172] Palliative Care NT, *Palliative Caring*, https://www.pallcarent.org.au/_files/ugd/1ba425_017fd2cf7625471698eaa3b74afb9c0d.pdf.
[173] Submission 153.
[174] Submission 153.
[175] Submission 171; Australian Medical Association NT, Public Hearing, Darwin, 5 August 2025.
[176] Submission 109.
[177] NT Health, Public Hearing, Darwin, 5 September 2025.

> I want to be at home to be buried and to die with my family. It is really hard. In Darwin, there is only one palliative care house on the back of the Darwin hospital. …We would like to see palliative care in our own community; we want it based here.[178]

3.28 In Gunbalanya, a community leader advised that:

> We are saying that if a person who is almost dying and is sent back to the community—but we need more support and health from the clinic. They come every now and then, visit and sit with the family and check when he is passing away.[179]

3.29 In Papunya, the Committee asked what kind of help is available in terms of palliative care and pain relief if someone is very sick. Former Member of the Legislative Assembly, Alison Anderson responded:

> Nothing. They go to Alice Springs and then we put them into palliative care in Alice Springs and we all have to go to palliative care in Alice Springs and farewell our loved ones there, then come home and perform sorry business here. We would like, as I said to you earlier…They want palliative care at home here.[180]

3.30 In Tennant Creek, the Mayor, Sid Vashist advised that:

> The aged-care sector is under significant stress all around the Northern Territory; we know that. In the Barkly we have a limited amount of beds for our transitional people who are potentially going into palliative care. People are actually moving out of country and they are relocating to Alice or somewhere else, which is a huge no culturally.[181]

3.31 This raises the genuine concern, expressed also to the 2024 Expert Panel that the absence of equitable access to high-quality palliative care undermines the capacity of genuine choice regarding VAD.[182]

3.32 Whilst the Committee heard there were deficiencies in palliative care services in the NT, stakeholders also highlighted some best practice examples. On 7 August 2025, the Committee visited the Malandari Aged Care Centre in Borroloola (Figure 9) which also supports people at the end of their life. It is an excellent example of the delivery of culturally safe palliative care.

[178] Meeting with St Matthew's Anglican Church, Ngukurr, 6 August 2025.
[179] Meeting with Gunbalanya School Board and staff, Gunbalanya, 19 August 2025.
[180] Meeting with community representatives, Papunya, 20 August 2025.
[181] Meeting with Barkly Regional Council and Tennant Creek Local Authority, Tennant Creek, 27 August 2025.
[182] Aboriginal Medical Services Alliance NT, Public Hearing, Darwin, 5 August 2025.

Case study: Malandari Aged Care Centre, Borroloola

The Malandari Aged Care Centre is run by the Mubanji Aboriginal Resource Indigenous Corporation. Most of the old people living at Malandari Centre are low care residents who need help to undertake daily activities like shopping and showering, but can mostly look after themselves. However, the centre sometimes receives requests from local Borroloola residents receiving palliative care in Darwin and regional hospitals to support them to die back on Country.[183] The centre can support these requests in partnership with the family who need to provide a team of carers to give 24 hour care. The family carers are supported by Aged Care staff and the health clinic.[184]

To be eligible to live at Malandari Centre a resident needs to be:

- frail;
- over 50 years of age;
- Aboriginal or Torres Strait Islander or recognised as a member of the Aboriginal community through marriage or close association; and
- have strong links to the local community but no one else to care for them.[185]

Malandari Centre is funded under an Australian Government grant designed to give remote communities, such as Borroloola, as much flexibility as possible to provide care for the elderly in the community. However, it is government policy that people living in aged care homes make a contribution to their care. Therefore, all long term and short-term residents are required to pay a fee for board and lodgings to stay at the centre.

The centre is different to other aged care facilities in that it has extensive open areas that allow large extended families to spend time with their dying loved ones including by pitching their tents in the grounds of the facility. Some units have a separate bedroom for family members. There are established shady gardens, a firepit area, vegetable patch, gazebo as well as wide verandas. A new laundry has recently been installed. Residents can eat their meals, prepared on site, in a common dining area or in their own rooms. For special occasions fresh seafood is gathered for residents. Traditional bush medicine is also prepared by residents and staff.

In the wet season, the centre supports approximately 22 residents and in the dry season there are 11 residents. The centre being able to support residents in the wet season is important for the region as access to the outer communities is often cut off during this period, limiting the reach of the health clinic and aged care. The centre is conveniently located nearby to shops and other services.

[183] Site visit to Malandari Aged Care Centre, Borroloola, 7 August 2025.
[184] Mabunji Aboriginal Resource Indigenous Corporation, *Malandari Aged Care Centre* (2025), https://www.mabunji.com.au/site/malandari-aged-care-centre/.
[185] Mabunji Aboriginal Resource Indigenous Corporation, *Malandari Aged Care Centre* (2025), https://www.mabunji.com.au/site/malandari-aged-care-centre/.

Figure 9: The Committee meeting with Mabunji and Malandari Aged Care Board members and staff

3.33 The role of palliative care in VAD was divided into two distinct groups in the written submissions and other evidence the Committee received. Opponents of VAD argued that palliative care should be prioritised over VAD.[186] Those in favour of VAD regard palliative care as complementary to VAD.[187]

3.34 How palliative care and VAD are delivered was also identified as important. Some experts stressed the need for the services to be delivered separately, at least initially, to maintain faith, confidence and trust in the health system for cultural safety reasons. Attitudes towards VAD interstate have evolved and as VAD has become more acceptable and mainstream it is increasingly interconnected with the wider health system and range of end-of-life choices. As the Australian Medical Association Northern Territory (AMA NT) explained:

> Our palliative care physicians have emphasised that they want to see a separation of VAD services from palliative care services. This is not because they do not want to run, control or be part of VAD services. There are palliative physicians that do want to be involved in VAD and those who do not. It mostly is to differentiate to

[186] Submissions 40, 57, 67, 82, 84, 156.
[187] Submissions 71, 153, 158, 167, 368.

> any member of the public who is looking to access VAD or palliative care that they are two different services with two very different foci.
>
> It is difficult enough to deliver culturally safe communication in our current model of healthcare, as I am sure you all know. The concept of individual autonomy, terminal illness and dying is hard enough in your native language and your own culture, let alone somebody else's. It is a difficulty we face on a daily basis in our health services. That is amplified in the VAD space. To that end, separation of the two services is essential to that initial safeguard. That is not to say that it might not change over time, but it is certainly how it should begin.[188]

3.35 In other Australian jurisdictions there is a significant overlap between people requesting VAD whilst receiving palliative care – approximately 80 per cent.[189] There is also a significant overlap of the healthcare workforce involved in palliative care and the delivery of VAD services.

3.36 The interface between VAD and palliative care has attracted substantial debate. Whilst some support VAD as an integral element of the palliative care system, others see VAD as contradictory to palliative care goals, arguing that it "compromise[s] the ethos of palliative care, and thus must be kept distinct".[190] For example, the views of palliative care physicians in the lead up to the introduction of VAD legislation in Victoria found a wide spectrum of opinions regarding VAD, however the majority were firmly against the legislation. It was concluded that the implementation of VAD legislation requires an active process to address the challenges it represents for palliative care physicians.[191]

3.37 Evidence received by the Committee highlighted that these services must be carefully integrated to ensure they are complementary rather than conflicting. Several stakeholders stressed that the introduction of VAD must not diminish investment in palliative care. Instead, VAD should be introduced alongside a substantial expansion of palliative care services to ensure all Territorians have access to a full spectrum of end-of-life options.

3.38 Experience from other Australian jurisdictions shows that the implementation of VAD tends to increase demand for palliative care services. This is due to:

- greater public awareness of end-of-life care options;
- more people seeking specialist care to explore both VAD and non-VAD pathways; and
- the need for comprehensive assessment and ongoing support for individuals considering VAD.

3.39 Some stakeholders suggested the NT must prepare for a similar increase in demand by strengthening existing palliative care systems, particularly in rural and remote communities. In their submission, NT Health's stated:

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[188] Aboriginal Medical Services Alliance NT, Public Hearing, Darwin, 5 August 2025.
[189] Submission 153.
[190] S. Javanparast, C. Phelan and P. Allcroft, 'Interface between voluntary assisted dying and palliative care in Australia: what evidence do we need to inform policy and practice?', *Internal Medicine Journal* 54 (2024).
[191] A. Holmes et al., 'Working with Palliative Care Physicians to Prepare for Voluntary Assisted Dying Legislation', *Australasian Psychiatry* 30(6) (2024).

> Crucially, other jurisdictions have experienced an increased demand of approximately 20% for Palliative Care services following the implementation of VAD. The NT will need to anticipate and fund a similar increase in Palliative care services (including improved outreach delivery) to provide a full range of clinical services for end-of-life care.[192]

3.40 Later estimates indicated the increase in palliative costs would be more likely to be 30 per cent with the introduction of a VAD service.[193] NT Health stated:

> From the perspective of palliative care, if we were talking about a 30% increase in running costs that would be a substantial increase overall for budget funding for palliative care.[194]

3.41 Dr Kane Vellar, NT Health, said:

> Currently, we are quite limited in what we can offer [palliative care] outside of the larger centres. That would be a necessary investment. We have seen interstate where VAD has been introduced that there is significant uptake in palliative care services at the same time. That has been shown in Victoria, South Australia and Western Australia…If we were to introduce VAD, it would be necessary to ensure that palliative care services are also expanded to be able to ensure patients have those options.[195]

3.42 A recurring theme in submissions was the need for clear separation of services, at least in the early stages of VAD implementation. This separation is vital for maintaining public trust and ensuring cultural safety, particularly for Aboriginal and Torres Strait Islander peoples. As the AMA NT explained, separating the two services provides clarity for patients and families about the different purposes of palliative care and VAD. It also acknowledges the diverse personal, cultural, and professional beliefs of healthcare workers who may choose to participate in VAD. Dr John Zorbas, President of AMA NT:

> …it is important that palliative care is kept paramount as a consideration. VAD should not be introduced to the threat or exclusion of palliative care resourcing. There needs to be clear separation between palliative care and VAD services initially. While that may change over time, it is the clear position of our palliative care physicians in the Northern Territory that there needs to be a separation of those two services to allow both services to function.[196]

3.43 Stakeholders also stressed that while initial separation is necessary, there should be pathways for collaboration and coordination between the two systems.[197] For example, palliative care teams often play a role in:

- providing information to patients about end-of-life care options, including VAD;
- managing symptoms and providing comfort care for individuals considering or proceeding with VAD; and
- supporting families before, during, and after a VAD process.[198]

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[192] Submission 369.
[193] Australian Medical Association NT, Public Hearing, Darwin, 5 September 2025.
[194] NT Health, Public Hearing, Darwin, 5 September 2025.
[195] NT Health, Public Hearing, Darwin, 5 August 2025.
[196] Submission 368.
[197] Submission 171.
[198] Submission 109.

3.44 Over time, as public and professional understanding grows, integration may naturally increase, similar to what has occurred in other jurisdictions. However, the Committee heard that this must happen gradually and with ongoing consultation, particularly with Aboriginal communities, to ensure cultural safety is never compromised.[199]

3.45 The Committee also noted the need for education and training. Health practitioners, including those in remote health clinics, require comprehensive training to navigate the ethical, clinical, and cultural dimensions of VAD alongside palliative care.[200]

Withdrawal from treatment

3.46 Under common law, all adults with decision-making capacity may consent or refuse medical treatment.[201] Withdrawing or withholding life sustaining treatment is a fundamental right of Australian adults. This stems from the premise that a person has the right to decide what is, or is not, done with their body.[202] A person may refuse medical treatment on any grounds, such as religious or cultural beliefs. NT guardianship and mental health legislation sets out strict parameters for substitute decision-making concerning medical treatment for adults who are incapable of giving consent.[203]

3.47 Choosing to withdraw from treatment can be the right choice at the right time for many people. Withdrawal from treatment often means that a person chooses to have, or to continue to have, palliative care to help the person have the best quality of life possible for their remaining time.

3.48 However, the Committee heard that Aboriginal people living in remote areas may sometimes withdraw from treatment and/or from palliative care, where they otherwise would choose to continue treatment or care, so they can return to County to die. As there may be no treatment or palliative care available on Country, this is the difficult and distressing decision some people make to be able to return home before they pass away.

3.49 Dr Chris Anderson, Specialist Doctor Palliative Care from the Alice Springs Hospital, outlined her view that there may be a culture within medicine that preferences continuing treatment for too long, noting that withdrawal from treatment cannot be left too late if a person wants to return to Country:

> I think all of the time I am here in the hospital and my doctors are here in the hospital advocating for; "don't leave it too late" this person is going to run out of time, they are going to miss their chance to go home. I think the hospital by default keeps treating people and probably too long sometimes; but this is a culture change, something about the way medicine works and the way we think… I'm the

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[199] Submission 109.
[200] Submission 109.
[201] *Brightwater Care Group v Rossiter* [2009] WASC 229; *H Ltd v J & Anor* [2010] SASC 176; *Re JS* [2014] NSWSC 302.
[202] Australian Law Reform Commission, *Equality Capacity and Disability in Commonwealth Laws* (DP 81), Chapter 10: Review of State and Territory Legislation – Informed consent in medical treatment, para 10.47-10.48; Queensland University of Technology, *Withholding and withdrawing life-sustaining treatment for adults, and guardianship law*, (2025) https://end-of-life.qut.edu.au/treatment-decisions/adults.
[203] *Guardianship of Adults Act 2016* (NT); *Mental Health and Related Services Act 1998* (NT).

> person that walks in the room and goes; "stop, stop, stop, stop, stop, stop everything". We need a family meeting now![204]

3.50 A community member in Ngukurr stated:

> That is the other thing, they keep pressuring our elders to go and get medication in Darwin. We do not want that. When they make their decision, we want them to accept it and stay here, and not have the clinic keep coming, 'We have got to take this old woman back to Darwin'. She went. She passed. We wanted her here.[205]

3.51 In Barunga, an interpreter from AIS, stated that sick people who are sent to hospital often do not make it back to their community:

> If anybody is sick, they just send them to Katherine or Darwin. That many family who have passed in Katherine Hospital in palliative care. If they send them to Darwin and then they realise there is nothing more they can do—if they are from Beswick, Barunga, Bulman… they bring them to Katherine. That is the closest they can get to their home.[206]

3.52 Lachlan Wilkins, CEO of Julalikari Council Aboriginal Corporation, relayed a story of a community member who wanted to continue renal treatment, but was unable to do so on Country:

> Yes, I will just reflect on a personal anecdote. I had a conversation with a lady in Ali Curung. Her sister was a renal patient, so she was in care. They were advocating to get renal services… on Country so that she could be on Country. The conversation she had was, to your point, they are sick of it. There is an emotional drain and a cultural drain, so first preference was to come back on country and continue renal. She expressed the preference of it is getting to the point where she would sooner come back and basically be on a palliative journey than continue to stay in Tennant Creek or have to go to Alice and be away from your family. It did not get to VAD, but that was, 'That is my preference. I would love to come back and see out my time on Country, even if that means I cannot get the care.' But obviously that was not the first preference. They were looking for options.[207]

3.53 A care provider in a remote community noted that the decision to return to Country may mean a person does not have a comfortable death:

> Can I just say that, at this stage, because of the lack of VAD laws in the NT a lot of these clients or patients are having to make a decision between Darwin and [Country]. …in order for them to die on Country, which is the most important thing to them and their culture, they have to forgo a comfortable death, the way things are. It is that simple. They will choose that every time. I have seen it time and again. They will come home with not the right palliative care, with not enough staff to look after them.[208]

Continuing treatment

3.54 It is an individual's personal choice to continue to have medical intervention and treatment of their illness or condition at any stage, for as long as they wish. However, as noted above in the 'Withdrawing from treatment' section, the Committee heard

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[204] Meeting with Alice Springs Hospital Palliative Care team, Alice Springs, 21 August 2025.
[205] Meeting with St Matthew's Anglican Church, Ngukurr, 6 August 2025.
[206] Meeting with community representatives, Barunga, 12 August 2025.
[207] Meeting with Julalikari Council Aboriginal Corporation, Tennant Creek, 28 August 2025.
[208] Meeting in a remote community, August 2025.

that the treatment or the palliative care services a person requires may not be available in the remote area that is their home. Therefore, those who wish to continue treatment or receive palliative care for their illness may need to make the decision to stay in a regional centre and die there rather than at home.

3.55 Many people choose varied levels of medical intervention at their end-of-life stages, and this may change as a person's illness progresses. Medical intervention may involve continuing treatment for a terminal illness. Some people want to try more aggressive treatments or be involved in clinical trials to slow progress of an illness such as cancer.[209] Medical intervention may also include continuing to get medical help to manage pain, whether a person continues treatment or not.

3.56 In Gunbalanya, multiple community leaders noted that dialysis used to be available in the community but that this is no longer an option. Sue Trimble, Principal of Gunbalanya School noted:

> …so many of our staff have family in Darwin and have to travel in and out to Darwin to see loved ones because they have to get treatment there.[210]

Committee comments

3.57 The Committee acknowledges the deeply personal nature of end-of-life choices and the diverse perspectives expressed across the NT. Territorians consistently highlighted the importance of dignity, comfort, family presence, and the ability to continue cultural practices at the end of life.

3.58 The Committee finds that these choices are often compromised by limited and inconsistent access to palliative care, particularly in remote areas. In many cases, people leave their home and community at the end of life, sometimes foregoing appropriate pain relief or specialist care. The Committee heard that these gaps create significant inequities, limiting Territorians' ability to make informed choices about how they wish to be cared for and who they wish to be with at the end of their life.

3.59 The Committee emphasises that high-quality, culturally safe palliative care must form the foundation of end-of-life care in the NT and the introduction of VAD should not come at the expense of palliative care services. Instead, VAD should sit alongside other end-of-life choices to provide a full spectrum of options. The Committee notes this aligns with the perspectives expressed in the 2024 Expert Panel Report.

3.60 The Committee notes that the challenges to palliative care will not be solved immediately. The Committee considers that there is a need to review existing services and develop a strategic framework. By strengthening palliative care and ensuring it works alongside VAD in a complementary way, the NT can create a system that provides Territorians with real and meaningful choices at the end of life.

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[209] National Cancer Institute, *Choices for Cancer Care When Treatment May Not Be an Option* (2024), https://www.cancer.gov/about-cancer/advanced-cancer/care-choices.

[210] Meeting with Gunbalanya School Board and staff, Gunbalanya, 19 August 2025.

Recommendation 3

The Committee recommends that the Government review current palliative care services and develop a Territory-wide palliative care strategy, recognising evidence and testimonies indicating increased need for palliative care services following the introduction of VAD.

4 VAD service delivery models

Possible service models

4.1 There are unique challenges to delivering VAD in the NT. To be successful, the service delivery model for VAD must be receptive to the healthcare context of the NT. This Chapter explores four distinct service delivery models: a centralised model, a community-based model, a hybrid model and an inter-jurisdictional shared model.

4.2 The 2024 Expert Panel Report recommended that the NT should develop and fund a single, centralised service for the delivery of VAD (Figure 10). This would include VAD practitioners, pharmacists and care navigators. Due to the very specific cultural safety concerns related to the provision of VAD, the service would be stand-alone, and clearly separate from existing NT Health facilities.[211]

4.3 The Committee does not support Recommendation 2 of the 2024 Expert Panel Report, but instead recommends a decentralised delivery model that may evolve over time.

Centralised model

4.4 The centralised model recommended by the 2024 Expert Panel Report would reflect the same processes as other jurisdictions but would be managed and administrated centrally by an NT Government funded and employed VAD service under the control of an oversight body, such as a Review Board.[212] The service would be operated separately from existing NT Health services and facilities.

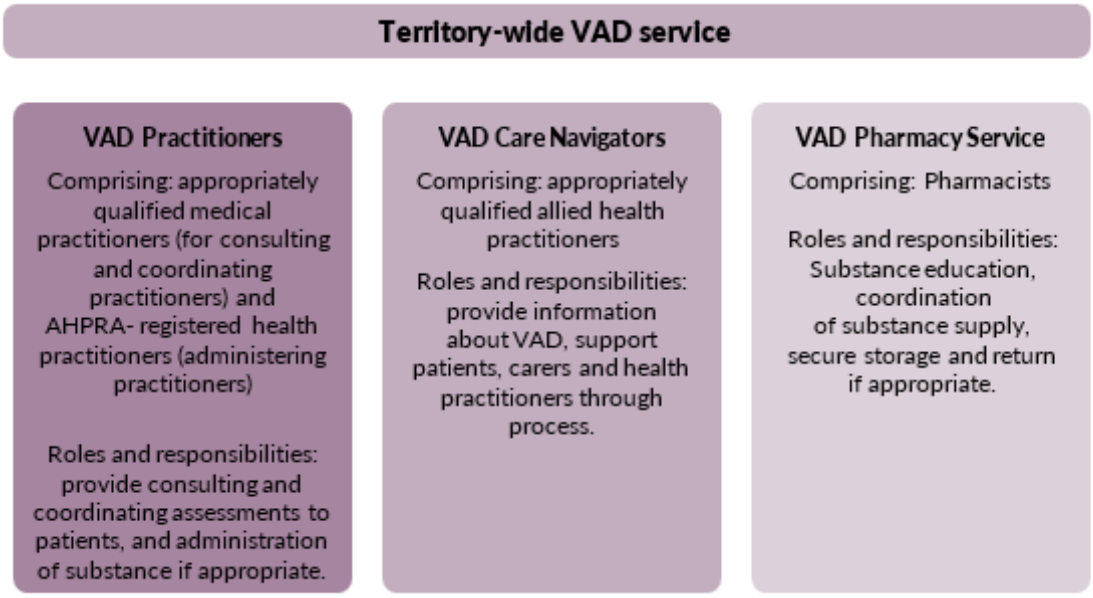
4.5 The dedicated VAD service team would offer an NT-wide VAD service. Patients would be referred to the centralised VAD service where VAD Practitioners, the Care Navigator Service and the Pharmacy Services would be co-located. This model has three key features:

- **VAD Practitioners** would be responsible for undertaking eligibility assessments (see Chapter 7) and be required to meet qualification and training requirements (see Chapter 10);
- A **VAD Care Navigator Service,** including interpreters, family support, counselling, and social and bereavement supports would support people seeking VAD, their friends, family or carers, and healthcare workers involved in VAD. Assistance could include providing information, helping a person to contact a VAD Practitioner, and referring people to other services and resources; and
- A **VAD Pharmacy Service** would oversee the supply, storage and disposal of the VAD Substance. The Pharmacy Service would be the sole supplier of the VAD Substance, and act as a central source of information and education about the

[211] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), Recommendation 2.
[212] See 'Review Board' section in Chapter 12 for more information.

VAD substance and its administration.[213] This may help ensure compliance with existing drugs and poisons laws.[214] It was anticipated that the Pharmacy Service would be unlikely to require full-time staff. Instead, trained and qualified pharmacists would be called in as needed.[215]

Figure 10: Proposed Model of VAD Service Delivery[216]



4.6 The Committee notes that potential strengths of this model include:

- Improved cultural safety (see Chapter 5 for a discussion of cultural safety and VAD);[217]
- Strong governance, oversight, and quality assurance due to the uniform nature of the model;[218] and
- Reduced risk of reputational impact on core health services due to perceptions that mainstream health services are related to VAD.[219]

4.7 Regarding the reputational risk, the Report noted concern that some community members may boycott health facilities if they feared they could receive "the death needle." The Committee notes that a similar argument was made regarding provision of termination of pregnancy services at Nhulunbuy Hospital. Initially there were concerns that women might avoid antenatal care at the hospital after the services were introduced, but this did not occur and antenatal attendance has continued.

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[213] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 32.
[214] *Medicines, Poisons and Therapeutic Goods Act 2012* (NT).
[215] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 32.
[216] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 15.
[217] Submissions 22, 109, 368, 369.
[218] Submissions 4, 170.
[219] Submissions 25, 97.

4.8 The Committee notes that potential weaknesses of this model include:

- High cost relative to small patient numbers;[220]
- Lack of staffing may create a barrier to access;[221] and
- Reduced continuity with a person's usual doctor.[222]

4.9 This model could be implemented as a fully funded centralised service or a part-time 'on call' centralised service:

1. A fully funded service would see the NT Government fund dedicated VAD roles within the health system (e.g. salaried positions or Full-Time Equivalents embedded in public hospitals or health services). These would be to cover a full-time type service.
2. A part-time 'on-call' service would see the NT Government fund health practitioners per episode of care (e.g. consultations, assessments, substance administration), possibly with standby or on-call payments. Travel time and administration costs could also be included.

4.10 No other Australian jurisdiction has implemented a system where VAD must be provided through a single, centralised service. Some jurisdictions such as Queensland and NSW have a statewide service that can provide VAD but these services generally function as a back up where local VAD provision is not available.

4.11 Many stakeholders to the Inquiry supported the development of a centralised service model. These views were informed by the necessity for cultural safety.

4.12 The Alice Springs Hospital Heads of Department outlined in their submission support for a centralised model which is easily accessible but separate from the mainstream NT Health facilities, particularly the palliative care facilities.[223] However, in subsequent consultations with the Committee, Dr Chris Anderson, Specialist Doctor Palliative Care, noted that the hospital will have patients who want VAD, but emphasised that palliative care workers should not be identified as VAD providers.[224] Refer to the section 'Participation by health or care entities' in Chapter 11 for further discussion of this evidence.

The Alice Springs Heads of Department acknowledged the potential for workforce shortages to act as a barrier to accessing VAD within a centralised model. They recommended that to address this:

> Backup arrangements (e.g., between Central Australia and Top End, or possibly by accessing providers from interstate) and rostering will need to be considered to ensure that VAD is in fact accessible as and when needed.[225]

[220] Submissions 35, 46.
[221] Submissions 35, 179.
[222] Submissions 35, 55.
[223] Submission 179.
[224] Meeting with Alice Springs Hospital Palliative Care team, Alice Springs, 21 August 2025.
[225] Submission 179.

4.13 Palliative Care NT also expressed support for the centralised model proposed by the 2024 Expert Panel Report, noting that distinguishing and separating palliative care and VAD is, in their view, critical for maintaining a culturally safe service:

> We strongly support the approach identified in the Report, which is for VAD services to be separate from other NT Health services. In particular, a separation between VAD and palliative care will be essential to ensure that palliative care services continue to be an accessible and culturally safe service for all Territorians. The establishment of culturally safe palliative care services that are well-accepted across the whole community has been the work of decades, and would be put at risk if VAD was to be administered within palliative care inpatient units.[226]

4.14 Irene Snell, Service Manager at Pulkapulkka Aged Care in Tennant Creek, outlined her support for a separate VAD service given the fact that some Aboriginal people already have a negative connotation of hospitals with death:

> In other facilities as well, I feel like if it is done in a hospital in some other Aboriginal facilities I have worked in, they already have a perception—the residents—that 'I do not want to go to hospital' because… like she says they associate that with death. If they are already thinking that, nothing is already happening there, I can only imagine that nobody would want to transfer to hospital when they are really unwell. That is what they wanted, but now they have got this perception, they do not want to do that anymore, so it kind of hinders their care. I think maybe a place that is made just for that; you would have to build it. That is kind of what I would see because I would see problems arising definitely.
>
> The dream scenario would be we had a standalone and fully staffed, and people are actually allowed to make those choices.[227]

4.15 NT Health argued for a centralised model in their submission, noting that a decentralised model could be particularly challenging to implement in the NT context:

> NT Health strongly advocate for VAD enabling legislation to maintain core centralised functions to ensure efficient and safe delivery of VAD in practice. These include: the establishment of an NT VAD Review Board, training and credentialing of practitioners, VAD navigation service and a VAD pharmacy service.
>
> The NT's unique geographic characteristics and demographic features (including a large First Nations population) presents considerable challenges to decentralising VAD implementation. These challenges are well documented and include access to medical practitioners, conscientious objectors, risks to health clinic staff, cultural safety concerns, clinical governance and safety and quality standards and compliance with legislation.
>
> Developing a model with core centralised functions ensures safe and accessible VAD that overcomes access barriers and provides confidence to the community that safeguards and standards are rigorously complied with. These centralised functions will further provide certainty of access, separate VAD from usual clinical practice, accommodate conscientious objectors, and ensure that highly trained and skilled clinicians are available.
>
> A careful calibration of legislative structures and operational regulations and policies is required to permit the development of a VAD program to best suit the

[226] Submission 109.
[227] Meeting with Pulkapulkka Kari Flexible Aged Care, Tennant Creek, 27 August 2025.

needs of the NT. We suggest that continued consultation with NT Health subject matter experts will be required to achieve this objective.[228]

A community-based model

4.16 All other Australian jurisdictions have adopted a decentralised, community-based model of VAD which enables VAD provision through both the public and private medical sectors.

4.17 In this model, medical practitioners who meet qualification and training requirements may register as a VAD Practitioner and undertake VAD eligibility assessments. However, they are not employed by a centralised VAD service and are left to self-manage VAD work. Care is usually led by the patient's treating team, most often general practitioners or local specialists.

4.18 There is no Australian Government funding available through Medicare specifically for medical activities related to VAD, nor can it currently be covered by private health insurance. As a result, much of the medical contribution to the VAD process that occurs in other jurisdictions is either unfunded, being managed by clinicians in addition to their existing workload or is occurring under private arrangements between patients and their doctors.[229]

4.19 However, there are three publicly funded, centralised elements of the community-based model, namely, the VAD Care Navigator Service, the Pharmacy Service and the Review Board.

4.20 The Committee notes that potential strengths of this model include:

- Potential for improved accessibility as VAD Practitioners may be more widespread;
- Improved continuity of care; and
- Flexibility for doctors.

4.21 The Committee notes that potential weaknesses include that:

- More widespread workforce training, supervision and support is required to maintain consistent safeguards, reporting and compliance, which can be resource-intensive and complex;
- Access and coverage may be unpredictable as some regions may have no willing doctors; and
- Due to the lack of Medicare funding, practitioners may resort to private billing, resulting in patients facing out-of-pocket costs which impacts equity of access to VAD.

4.22 The Australian Lawyers Alliance (ALA) expressed support for a VAD service delivery model that is similar to other Australian jurisdictions based on the view that this type of model would be more accessible to patients and better for continuity of care, noting

[228] Submission 369.
[229] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 29

that the NT's unique geographic, demographic and cultural contexts need to be accounted for:

> The ALA also questions the benefit of a centralised Voluntary Assisted Dying service operating separate to existing NT Health services, facilities and processes. Given the advanced and terminal health conditions faced by those seeking to access Voluntary Assisted Dying, we contend that it will be in the best interests of those patients and their support networks that those seeking to access Voluntary Assisted Dying can do so within the health system they are already navigating and through facilities where their oncologists, neurologists, geriatricians, palliative care physicians, et cetera already work.
>
> We are also concerned that separating out Voluntary Assisted Dying services may stigmatise access to this legal, end-of-life option.
>
> Further, if the Northern Territory Government's intention is for Voluntary Assisted Dying services to be accessible outside of Darwin and Alice Springs (and those services should absolutely be available across the Territory), the ALA questions the cost involved in setting up separate rural and remote Voluntary Assisted Dying services under the proposed centralised model – instead of implementing the scheme through existing NT Health rural and remote services and facilities in the Northern Territory, and in the process also providing additional funding to improve those existing facilities. The ALA supports the latter option.
>
> The ALA would, therefore, support the Northern Territory implementing a Voluntary Assisted Dying scheme which is structured in a way akin to the state and territory schemes – that is, health professionals must register as a Voluntary Assisted Dying practitioner and have completed all necessary training, but are not separately employed under a Voluntary Assisted Dying service. Particular, local considerations for the implementation of a Voluntary Assisted Dying scheme in the Northern Territory would, of course, need to be factored into the roll-out of that scheme. That would include cultural considerations for Aboriginal and Torres Strait Islander Territorians whose preference may be to die on Country. This would also include geographical considerations and, given the layout of the Northern Territory, we urge the Committee to recommend that the Northern Territory Government advocate for the necessary Commonwealth reforms to allow for the use of Telehealth for at least one of the Voluntary Assisted Dying consultations.
>
> The ALA, therefore, maintains that a Voluntary Assisted Dying scheme in the Northern Territory will operate more seamlessly and will be more accessible as part of NT Health's existing services and structures, not as a separate/centralised service.[230]

4.23 Marshall Perron, former Chief Minister of the NT, expressed the view that a centralised model would be overly bureaucratic and unnecessary given the likely small number of people in the NT who would use VAD:

> While the concept and reasoning in the report is sound, it envisages an overly bureaucratic/staffed structure considering the tiny number of prospective applicants. The probable number based on the Australian experience shows likely applicants at less than one per month.[231]

4.24 NT Health provided a specific estimation of the number of people in the NT who would be likely to access VAD services:

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[230] Submission 157.
[231] Submission 35.

> During our public hearing presentation, we extrapolated from the Victorian statistics to estimate the number of deaths occurring, using VAD, would amount to between 8 and 12 deaths per year. Within other Australian jurisdictions, the total number of deaths range from 0.5% to 1.5% of total deaths within that jurisdiction. These factors are influenced by the nature of legislation within each jurisdiction (access). However, it is important to stress that the number of deaths will be a minor proportion of patients consulting a VAD service during their terminal illness.
>
> Reported utilisation figures should discern between those who are ineligible, those who are eligible but choose not to proceed with VAD and those who ultimately proceed with VAD.
>
> Conservative estimates of service utilisation for the NT are likely to be in the order of one to two patients per week (up to 100 patients a year) consulting a VAD service.[232]

4.25 NT residents, Dave and Doreen Dyer, raised concerns about the potential strain that a centralised service might place on the NT:

> We don't believe that the service should be limited to a centralised VAD model. Already we do not have enough health practitioners in the NT for existing service. If the numbers for VAD are low, then having a dedicated team will be expensive, cumbersome and unwieldy. There does need to be a small team that oversights the VAD program, training and reviews.[233]

Hybrid model

4.26 There are many options for hybrid models that incorporate elements of centralised and community-based service design. AMA NT outlined one 'hub and spoke' option:

> In response to the Committee's request for a more tangible operational model, the AMA NT proposes a "Hub and Spoke" structure. This model integrates the recommendation for a centralised service with the practical realities of delivering outreach services across the Territory, drawing lessons from the regional access schemes in Western Australia and Queensland.
>
> - **Hubs**: The model would be based around two primary service hubs, one in Darwin to serve the Top End and one in Alice Springs for Central Australia. These hubs would be the administrative and clinical core of the service. They would be co-located with other health infrastructure for efficiency but must remain operationally and physically distinct from palliative care services like hospices to maintain the critical separation of services.
> - **Staffing**: Each hub would be staffed by a small, permanent team comprising a clinical lead (a senior physician with experience in end-of-life care), VAD care navigators (experienced nurses or allied health professionals who would be the primary point of contact for patients), and administrative support. This core team would be supplemented by a pool of trained and credentialed VAD practitioners (coordinating and consulting practitioners) engaged on a sessional or on-call basis from the local medical community.
> - **Patient Journey (Urban/Regional)**: For a patient in Darwin or Alice Springs, the process would be straightforward. A referral from their GP or a self-referral would be made to the local hub. A care navigator would be assigned and would manage the entire process, coordinating assessments with the VAD

[232] Submission 369.
[233] Submission 46.

practitioners, which could take place at the hub's facility, the patient's home, or their residential aged care facility.

- **Spokes (Remote Access)**: The outreach component is the most critical element.
    - Initial Contact: A patient or their local clinician in a remote community would contact the nearest hub. The care navigator would manage the initial information exchange, strictly adhering to the legal constraints of the *Criminal Code Act 1995*.
    - Assessment: The service would utilise a fly-in, fly-out (FIFO) model for assessments. A trained VAD practitioner from the hub would travel to the patient's community to conduct the mandatory in-person assessment. This travel would be fully funded by a dedicated Northern Territory Regional Access Support Scheme (NT RASS).
    - Coordination: The VAD service would be required to work in close partnership with existing remote health services, particularly Aboriginal Community Controlled Health Organisations (ACCHOs), to ensure assessments are conducted in a culturally appropriate, safe, and logistically sound manner.
    - Administration: For practitioner administration, the administering practitioner would travel to the patient. For self-administration, the Statewide Pharmacy Service (based at the hubs) would coordinate the secure and timely delivery of the VAD substance, adopting the logistical solutions developed by the WA Statewide Pharmacy Service for managing supply to remote areas.[234]

4.27 NT resident, Shirley Hendy, supported a hybrid model so as not to prevent a person's usual medical practitioner from being their VAD Practitioner, while also ensuring there is centralised coordination of the service:

> But no model should deny a terminally ill person this End of Life care from their own doctors (and other healthcare team members) with whom they have an established relationship. Rather than excluding a person's own GP or treating Specialist, it is surely possible to develop a hybrid service.
>
> Central Coordination will be needed to keep a register of VAD trained practitioners, provide Care Navigation support, process requests for travel funding etc, and could identify and organise VAD Practitioners who have nominated to provide such services, including to travel to remote areas to deliver VAD services.
>
> The purpose of VAD services is to relieve intolerable suffering by someone with a terminal illness - part of compassionate End of Life Care. The reasoning for a separate Agency is understood, but it is not reasonable to allow the unfounded fears of some to separate it from NT Health which is its logical location.
>
> As in other jurisdictions, there should be funding both for VAD Practitioners to travel to deliver services, and for a person requesting VAD to travel from a remote location to access VAD services.[235]

[234] Submission 368.
[235] Submission 55.

Inter-jurisdictional shared model

4.28 A model that is shared with another Australian jurisdiction would involve the NT contracting an interstate VAD service to provide VAD Practitioners (FIFO or eventually telehealth), and/or centralised services.

4.29 Practical options for what could be shared include:

- Clinician capacity on contract: Use Queensland-credentialed VAD clinicians (fly-in fly-out) for assessments or Practitioner Administration under NT law, with NT paying sessional/fee for service rates and travel. Queensland has already funded clinician travel within its state due to telehealth limits, illustrating a workable access approach for spread-out geographies. Locum contracts are already common permitting interstate doctors to practice in the NT;
- Protocols, training, forms, IT templates: License or adapt Queensland standard operation procedures, checklists, training modules, and case management workflows to reduce setup time and cost; and
- Second opinions / surge cover: Establish memorandums of understanding for on-demand second-assessor panels, case conferencing, and peer review to backstop a small NT clinician pool.

4.30 The strengths of this approach could be that it may allow for:

- Leveraging of existing clinical expertise and systems; and
- High-quality service provision while local capacity builds.

4.31 Weaknesses of this approach could be that it:

- Would not align well with cultural needs or NT-specific contexts; and
- Would be harder to ensure integration with NT health services.

4.32 It is contested whether this model would be feasible or legislatively possible, with NT Health noting in their submission that:

> While it may appear feasible to partner with another jurisdiction that offers VAD, this approach is misguided inasmuch that it is neither legally feasible nor sustainable as a substitute to the NT context. The NT must prepare is own authorising legislation that is supported by a contextual regulatory and operational framework for Territorians.[236]

Co-design with Aboriginal communities

4.33 Co-design is a public policy approach where government agencies work with affected communities to better understand problems and create solutions together. Effective co-design requires embedded cultural safety, shared power in decision-making and tailored approaches.[237] It promotes equitable access to healthcare. This aims to make

[236] Submission 369.
[237] National Indigenous Australians Agency, *Co-Design Lessons Learned Report* (2023), https://www.niaa.gov.au/sites/default/files/documents/2024-05/co-design-lessons-learned-report.pdf.

sure support services are sensitive to changing local contexts and needs of communities.

4.34 Other jurisdictions have incorporated the views of Aboriginal and Torres Strait Islander people into their VAD models. In the context of South Australia (SA), SA Health works with the Aboriginal Health Council of SA and Aboriginal Community Controlled Health Organisations (ACCHOs) to co-design the VAD service delivery model. Consideration should be given to how peak bodies and ACCHOs could be included in a co-design process.

4.35 The co-designed model of VAD care is expected to include:

- The development of ways to talk about death, explain what VAD is, and how it can be accessed, as many of the concepts around death and dying have different meanings and interpretations, particularly in Aboriginal languages;
- The role of family and community and how to support decision-making about VAD; and
- Pathways for VAD teams to work with trusted healthcare workers to visit country to support a request for VAD, and to facilitate medication supply and dying on country.[238]

4.36 AMSANT noted that resourcing would be required to enable genuine co-design of a VAD model moving forward:

> …if the next stage of VAD investigation/legislative development is to proceed, substantial resourcing will be required to consult and engage appropriately with Aboriginal people across the NT. This should be co-designed with Aboriginal Peak Organisations Northern Territory (APO NT) and should be resourced properly to enable an authentic co-design and engagement process.[239]

AMSANT additionally raised that a "social/cultural approach to the design and governance of VAD" is required:

> …VAD is not exclusively a medical issue and to limit governance arrangements to include clinicians alone ignores the deep cultural and social significance of the issues associated with the process of dying, death and grieving. Medically managing the process of dying and death is only one consideration and AMSANT supports a process that fully considers the range of cultural, social and emotional wellbeing factors associated with VAD, and the design and establishment of holistic governance mechanisms to address these in culturally safe and appropriate ways.[240]

4.37 AMA NT also emphasised the importance of effective and authentic co-design of a VAD model with Aboriginal people:

> The 2024 Report and the Committee's Consultation Paper correctly identify that addressing the cultural safety of Aboriginal and Torres Strait Islander peoples is a core, non-negotiable requirement of any VAD framework in the NT. The AMA NT's verbal testimony further stressed the need for genuine co-design with Indigenous communities and the critical role of appropriately trained interpreters.

[238] Submission 203.
[239] Submission 403.
[240] Submission 403.

> The concept of co-design must be understood as more than simple consultation. Best-practice frameworks for co-designing health services with Aboriginal and Torres Strait Islander peoples emphasise the need to move beyond tokenistic engagement towards genuine partnership. This involves sharing power, facilitating Indigenous leadership, building trusted relationships before developing solutions, and privileging Indigenous knowledge systems and ways of knowing, being, and doing.
>
> There is a significant risk that "co-design" becomes a checkbox item to be addressed during the 18-month implementation phase after legislation is passed. This would be a profound mistake. Effective co-design, which builds the trust necessary for a culturally safe service, cannot be rushed and must precede operationalisation. It requires ceding decision-making power to Aboriginal and Torres Strait Islander partners to determine how the VAD service will respectfully interact with their communities, how complex concepts like "capacity" and "voluntariness" are communicated in a culturally resonant way, and how family, kinship, and community decision-making structures are respected within the VAD process.
>
> The AMA NT recommends that the Committee's report call for the NT Government to fund and establish a formal, Indigenous-led co-design process. This process must be conducted in genuine partnership with key bodies such as the Aboriginal Medical Services Alliance Northern Territory (AMSANT). Its mandate should be to develop the culturally-specific protocols, communication strategies, interpreter training modules, and operational guidelines for the VAD service. This foundational work must be completed before the 18-month implementation period for the broader service begins, as it is essential for the legitimacy, safety, and cultural integrity of the entire system.[241]

4.38 Urapuntja Health Service Aboriginal Corporation highlighted the need for ACCHOs to be built into the VAD model of service delivery:

> A standalone service model is appropriate, but it must include strong relationships with Aboriginal Community Controlled Health Organisations (ACCHOs).[242]

Evolving models of care

4.39 NT Health recommended against legislating a specific VAD service delivery model in the NT, noting that the model is likely to evolve over time:

> …subject to national legislative reform (for example, permitting the use of telehealth) and NT-specific continual quality improvement efforts for a future VAD program. NT Health has excellent clinical governance capacity that will be of great utility to the legislation drafting team.[243]

4.40 Dr Jeremy Chin, Chief Medical Officer (CMO), noted that not being overly prescriptive in the VAD legislation about the VAD service delivery model will ensure that nuanced policy and operational decisions are able to be made:

> I think the objective of legislation is to provide an authorising and regulatory environment… the nuances do change over time as the community becomes more accepting.
>
> For the legislation drafting, we need to be thinking about leaving that or having a tight focus on the enabling environment, authorisation environment, patient and staff safety, medication safety—those issues. I think the bare minimum we have

[241] Submission 368.
[242] Submission 22.
[243] Submission 369.

already articulated around a navigation service and an independent board to oversee the operation of VAD.

We will inevitably see evolving models of care as this rolls out. It might be an operational matter to begin with, as I witnessed and tried to explain to you, where we have a preference for VAD at home or VAD on country due to patient preferences. Inevitably there will be individuals who have more complicated journeys. There becomes the nuance, but that is an operational matter, not necessarily a legislation drafting instruction…

I will give an example of how this could work out to be very theme appropriate in principle, but at the end of the day work out to be quite strange. If, for example, we decide collectively that VAD would not happen on NT Health facilities, but there is a great need from the community and there are the appropriate clinicians and a location for those who felt it was inappropriate or not ideal to take the substance at home, then there could be awkward situations where structures are set up to lease—for example, a house or a location where it would be appropriate. At the end of the day it comes out to the same wash. The money is coming from the same bigger bucket and the clinicians providing the service are the same clinicians providing the service. The consumer is still the same consumer and patient.

I worry that in this particular scenario where we start creating blanket rules that the workarounds we found will end up in a similar position anyway in the medium to long term as perceptions, community consultation, co production and then health literacy about VAD and its actual place in our community become much broader. [244]

Committee comments

4.41 The Committee recognises the merits of a standalone, centralised model, including the fact that this model was identified by stakeholders to be the most culturally safe for Aboriginal people. However, the Committee acknowledges that the feasibility of this model may be constrained due to the high cost to small patient number ratio.

4.42 The Committee notes that VAD legislation in other states does not mandate a particular type of service delivery, and models of care have largely been shaped by policy decisions. Detailed service design and delivery arrangements may be developed through policy and operational planning, rather than being prescribed in legislation.

4.43 Recommendation 2 of the 2024 Expert Panel Report is that a single, centralised service should be developed to deliver VAD in the NT. The Committee departs from this recommendation. While leaving open the possibility of a centralised service being developed to deliver VAD services in the NT in future, the Committee's view is that VAD will be provided in the NT via a decentralised delivery model. This reflects the broader Australian approach to providing VAD via the public and private sectors (which includes general practitioners). Accordingly, the drafting instructions were developed to facilitate a decentralised delivery model while leaving open the possibility of a future centralised model of VAD service delivery.

4.44 The Committee emphasises that a service delivery model for VAD in the NT should be co-designed with Aboriginal people, with support from, and engagement with,

[244] NT Health, Public Hearing, Darwin, 5 September 2025.

ACCHOs. The model needs to be culturally responsive, accessible, and mindful of the NT's geography, workforce limitations, and population diversity.

4.45 The Committee appreciates that the service delivery model options interact and crossover with one another, and that they will evolve over time to meet the needs of the NT population.

Recommendation 4

The Committee recommends that VAD should be provided in the NT via a decentralised delivery model, consistent with the Australian VAD model.

5 Purposes and principles

Overview

5.1 This Chapter includes recommendations for preliminary VAD legislative provisions, including the purpose of the legislation, the guiding principles and certain terminology. Such provisions provide courts, legislators, policy makers and health practitioners with valuable guidance and parameters within which to interpret and operationalise a VAD scheme. They also assist the community in understanding the intent of the law, how they are protected under VAD legislation, and the circumstances in which they can access it.

Purposes of the legislation

5.2 The 2024 Expert Panel Report did not make a formal recommendation regarding the purpose of VAD legislation in the NT. However, the Committee considers that explicitly stating the purpose of the legislation is important. Doing so will provide clarity around the guiding objectives that underpin the legislation.

5.3 In a common law context, the Committee notes that clearly outlining the purpose of legislation will assist in how it is interpreted by the courts, which increasingly adopt a purposive approach to statutory interpretation (i.e., legislation is interpreted based on its objectives rather than the exact wording of provisions).[245]

5.4 In addition, the Committee recognises that articulating the purpose of VAD legislation will help guide the development of future delegated legislation and policy during the implementation phase of VAD in the NT. The Committee considers this particularly important, noting that much of the VAD framework may be established during the implementation phase in regulations and policy guidelines.

5.5 Whilst it is not common practice to include a purpose provision in NT legislation, the Committee is aware that there are prominent examples where one has been included.[246]

Approaches in other jurisdictions

5.6 Some other Australian jurisdictions include provisions which expressly state the purpose of their VAD legislation,[247] whilst other do not. This varies across jurisdictions depending on their legislative drafting conventions. In general, the Committee notes these provisions have been incorporated to ensure the legislation "simply, accurately and unambiguously state its intent".[248]

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[245] D. Pearce, *Statutory Interpretation in Australia – 9th Edition* (2019), p. 40.
[246] See for example, *Burials and Cremation Act 2022* (NT), s 3.
[247] See for example, *Voluntary Assisted Dying Act 2017* (Vic), s 1; *Voluntary Assisted Dying 2021* (Qld), s 3; *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas), s 3.
[248] Queensland Department of Premier and Cabinet, *Legislation Handbook*, section 3.5.

5.7 In other jurisdictions, the stated purposes of VAD legislation include to:

- provide access to VAD for eligible persons to enable them the choice to reduce suffering and end their life legally;[249]
- protect healthcare workers who choose, or who choose not to, assist with VAD;[250]
- to establish safeguards to:
  - ensure it is accessed only by persons who have been assessed to be eligible; and
  - protect vulnerable persons from coercion and exploitation;[251]
- to establish Review Board and other mechanisms to ensure compliance;252 and
- to make consequential amendments to other legislation.[253]

Evidence before the Committee

5.8 Professor Lindy Willmott and Professor Ben White et al. point to the difficulty in translating policy objectives of VAD into legislation. They note:

> One implication is the long-standing policy challenge of using words in legislation to accurately reflect a stated policy intent. The translation of broader social objectives into concrete legal rules is a challenging exercise. Problems can arise not only in the selection of words, but also their interpretation, both by the courts and by those at the coalface who are charged with implementing the law. An ideal law is precise and can be applied consistently in relation to a wide variety of situations to which the law is intended to apply. But legal rules are 'inherently indeterminate', both because language is imprecise, and because they are subject to interpretation by others. Precision in wording can require compromises in terms of the congruence of the law with the policy goals underpinning it.[254]

5.9 The Committee did not receive any evidence specifically about purpose provisions. It did, however, receive limited evidence on the overarching objectives of the Act. In general, stakeholders highlight the need to explicitly state the objective of the Act is to provide choice and relieve suffering.[255] The NT Voluntary Euthanasia Society contended that the objective of VAD legislation should be "allowing a citizen access to the means of a tranquil death is to relieve unbearable suffering".[256]

Committee comments

5.10 The Committee considers it appropriate to include a purpose provision in VAD legislation. This will influence future statutory interpretation, the making of delegation

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[249] *Voluntary Assisted Dying 2021* (Qld), s 3(1); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas), s 3(1)(a); *Voluntary Assisted Dying Act 2017* (Vic), s 1.
[250] *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas), s 3(1)(b).
[251] *Voluntary Assisted Dying 2021* (Qld), ss 3(c)(i) and (ii).
[252] *Voluntary Assisted Dying Act 2017* (Vic), s 1(b); *Voluntary Assisted Dying 2021* (Qld), s 3(e).
[253] *Voluntary Assisted Dying Act 2017* (Vic), s 1(c).
[254] B. White et al., 'Comparative and Critical Analysis of Key Eligibility Criteria for Voluntary Assisted Dying under Five Legal Frameworks' (2021), *University of New South Wales Law Journal* 44(4).
[255] Submissions 157, 83.
[256] Submission 83.

legislation, and future policy development. The Committee considers it appropriate to be consistent with other jurisdictions who include such provisions in their legislation.

5.11 The Committee considers that the legislation must recognise the unique geography and demography of the NT (discussed in Chapter 2). Accordingly, the Committee recommends expressly noting the purpose of the legislation is to provide for end-of-life choices to meet the unique geographic and demographic context of the NT.

Recommendation 5

The Committee recommends the purposes of the NT VAD legislation are to:

- **a. Give persons who are suffering and dying and who meet eligibility criteria, a legally authorised option to hasten their death by medical assistance;**
- **b. Establish a lawful process for eligible persons to exercise that option;**
- **c. Provide legal protection for health practitioners who assist persons to die in accordance with the legislation;**
- **d. Establish safeguards to:**
  - **i. Ensure VAD is accessed only by persons who have been assessed as eligible; and**
  - **ii. Protect vulnerable persons from coercion and exploitation;**
- **e. To establish a Review Board and other mechanisms to ensure compliance with this legislation; and**
- **f. Recognise the unique demography and geography of the NT in which VAD will be delivered.**

Guiding principles

5.12 The Australian model of VAD adopts a principles-based approach.[257] The Committee notes a principles-based model of legislative design:

> …seeks to provide an overarching framework that guides and assists regulated entities to develop an appreciation of the core goals of the regulatory scheme. A key advantage of principles-based regulation is its facilitation of regulatory flexibility through the statement of general principles that can be applied to new and changing situations. It has been said that such a regulatory framework is exhortatory in that it emphasises a "do the right thing" approach and promotes compliance with the spirit of the law.[258]

5.13 The Committee notes there are some existing examples of principles included in NT legislation.[259]

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[257] L. Willmott and B. White, 'Assisted dying in Australia: a values-based model for reform' (2017), in I. Freckelton and K. Petersen (eds) *Tensions and Trauma in Health Law*, *The Federation Press*, pp. 479-510.
[258] Australian Law Reform Commission, *For Your Information: Australian Privacy Law and Practice (ALRC Report 108)* (2008), https://www.alrc.gov.au/publication/for-your-information-australian-privacy-law-and-practice-alrc-report-108/.
[259] See for example, *Surrogacy Act 2022* (NT), s 6.

5.14 The 2024 Expert Panel Report did not make a formal recommendation on the principles that should be reflected in VAD legislation. The 2024 Expert Panel did, however, recommend the process for addressing Aboriginal and Torres Strait Islander cultural safety issues being designed and resourced as a core part of the operationalisation of VAD.[260]

5.15 Cultural safety is about how the experience of individuals' care, ability to access services, and raise concerns, is safer when health practitioners have considered cultural contexts, power relations, and individual rights.[261] The Committee notes there are existing NT policies covering cultural safety and cultural security. Cultural security, is defined in the *NT Health Aboriginal Cultural Security Policy* (2021) as:

> …a commitment to the principle that the construct and provision of services offered by the health system will not compromise the legitimate cultural rights, values and expectation of Aboriginal people. It is achieved by developing accessible and effective health care systems for Aboriginal people based on acknowledgement of Aboriginal people right to self-determination, empowerment and healthcare and as such, an understanding and responsiveness to cultural views, beliefs and knowledge systems which play an integral role in adherence to health care.[262]

5.16 As explained in the *NT Health Aboriginal Cultural Security Framework 2016-2026*, part of this process requires health professionals to examine their own realities, beliefs and attitudes.[263] The framework further explains that cultural safety is not defined by the health professional, but is defined by the health consumer's experience – the individual's experience of care they are given, ability to access services and to raise concerns.

5.17 The progress achieved under the 10-year strategy is unclear to the Committee. The framework states that "Reporting against cultural security is an emerging field… NT Health will continue research in this area and improve indicators to support robust reporting".[264] At a public hearing, Dr Paul Burgess, Chief Health Officer (CHO), NT Health advised the Committee that:

> Within Northern Territory Health, our Aboriginal health engagement and workforce division have developed a cultural safety plan and they are in the process of reviewing and refreshing that and looking for implementation and also a quality assurance process as well to shore up the cultural safety, particularly for First Nations having contact with our NT Health system. That is an active area of management, if you like, within NT Health and a high priority for our Aboriginal health engagement and workforce division.[265]

5.18 Not only is ensuring cultural safety a human right and best practice healthcare, it has become a concern for all health practitioners due to recent updates to the Health Practitioner Regulation National Law administered by the Australian Health

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[260] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), Recommendation 6.
[261] NT Government, NT Health, *Aboriginal Cultural Security Framework 2016 – 2026* (2016), p. 6.
[262] NT Health, *Aboriginal Cultural Security Policy* (2021), p. 5.
[263] NT Government, NT Health, *Aboriginal Cultural Security Framework 2016 – 2026* (2016), p. 6.
[264] NT Government, NT Health, *Aboriginal Cultural Security Framework 2016 – 2026* (2016), p. 25.
[265] NT Health, Public Hearing, Darwin, 5 September 2025.

Practitioner Regulation Agency (AHPRA).[266] This now allows patients to make a notification against a registered health practitioner for culturally unsafe care, recognising such conduct as a breach of professional standards.[267]

Approaches in other jurisdictions

5.19 There are a number of principles in Australian VAD legislation based on existing Australian legal principles, as reflected in common law, legislation or conventions or treaties that have been ratified by Australia.[268] Professor Ben White and Professor Lindy Willmott explain how such core values interact and fit together, as follows:

> Allowing assistance to die enables a competent adult to assess and balance the value of their life and the disvalue of their suffering and to exercise their autonomy. This promotes both the values of life and autonomy. The value of conscience can be promoted by allowing health professionals the freedom not to participate in assisted dying as well as through an appropriately constructed system for transfers of care. The regime should ensure access to assisted dying for competent adults (autonomy) and eligibility criteria must avoid unjustifiable discrimination, including on the basis of disability (equality and the rule of law). The value of the rule of law can also be promoted through clearly expressed legal parameters about access to assisted dying and established safeguard sand oversight mechanisms to ensure the law is followed. A regime with adequate safeguards (which empirical evidence demonstrates can be effective) can also serve the value of protecting the vulnerable. By respecting a person's decision to seek assistance to end their life when they are experiencing intolerable suffering, the value of reducing suffering, as assessed by the person, is also promoted. In summary, these values demonstrate the need for reform and that sometimes competing claims can be accommodated in a regime the permits and regulates assisted dying.[269]

5.20 The Committee notes there are a number of key principles across jurisdictions. These include, for example:

- Every human life is of fundamental importance;
- A person's autonomy, including autonomy in relation to informed end-of-life choices, should be respected;
- A person's decision to include chosen others in decision-making about end-of-life choices should be respected;
- A person should be supported in making informed decisions about end-of-life choices;
- A person approaching the end of life should be provided with high quality care and treatment, including palliative care and treatment, to minimise the person's suffering and maximise the person's quality of life;

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[266] The Health Practitioner Regulation National Law is adopted in the NT as in force from time to time by the *Health Practitioner Regulation (National Uniform Legislation) Act 2010* (NT).

[267] E. B. Waugh et al., 'What do Aboriginal people in the Northern Territory value during the operation journey? A Qualitative study', *Medical Journal of Australia* 223 (1) (2025), p. 34.

[268] L. Willmott and B. White, 'Assisted dying in Australia: a values-based model for reform' (2017), I. Freckelton and K. Petersen (eds) *Tensions and Trauma in Health Law*, The Federation Press, pp. 479-510.

[269] L. Willmott and B. White, 'Assisted dying in Australia: a values-based model for reform' (2017), I. Freckelton and K. Petersen (eds), *Tensions and Trauma in Health Law*, The Federation Press, pp. 479-510.

- A therapeutic relationship between a person and the person's registered health practitioner should, wherever possible, be supported and maintained;
- A person should be protected from coercion and exploitation; and
- Access to voluntary assisted dying and other end-of-life choices should be available regardless of where a person lives in the relevant jurisdiction.

Cultural Safety

5.21 Significantly, there are no guiding cultural safety principles built into VAD legislation in other Australian States and Territories. The Committee's recommended approach is consistent with the VAD legislation in other Australian jurisdictions, with one significant variation: the inclusion of a cultural safety principle.

5.22 Other jurisdictions have incorporated the views of Aboriginal and Torres Strait Islander people into their VAD models, including co-design with ACCHOs (see Chapter 4 for a full discussion).

5.23 Additional guidelines for Aboriginal and Torres Strait Islander people are an option to help ensure equity of access to VAD. NSW and Queensland provide specific guidance to Aboriginal and Torres Strait Islander people.[270] This guidance includes information about the VAD process, the role of family and community in VAD decision-making, help with communicating, and support for returning to Country and dying on Country.

[270] Queensland Government, Voluntary Assisted Dying Queensland, *Information for Aboriginal peoples and Torres Strait Islander peoples* (2025), https://www.qld.gov.au/__data/assets/pdf_file/0025/336841/QVAD-Information-for-Aboriginal-peoples-and-Torres-Strait-Islander-peoples.pdf; NSW Government, *Information for Aboriginal communities* (2025), https://www.health.nsw.gov.au/voluntary-assisted-dying/Pages/aboriginal-communities.aspx.

Case study: Victoria First People's Consultation: Five-year review of the operation of the *Voluntary Assisted Dying Act 2017*

A review was undertaken by Torres Strait Islander consulting firm, Karabena Consulting, focusing on Aboriginal and Torres Strait Islander people's experience of VAD in Victoria. It found that the current transactional and impersonal nature of end-of-life care does not align with the cultural values and needs of First Nations communities. It concluded that to provide truly compassionate and respectful end-of-life care, narratives focussing on clinical efficiency and risk reduction, and meeting legislative requirements rather than providing culturally sensitive care, must change.

It found that practitioners could adopt a more culturally sensitive approach that prioritises relational care, community involvement and the emotional and spiritual needs of the person.

It recommended:

- People be informed about their rights and awareness about VAD (in the short term, 0-1 year); and
- A culturally competent workforce be developed who can facilitate ceremonial and clinical end-of-life practices (in the medium term, 1-3 years); and
- Working with services to ensure Aboriginal-centric end-of-life VAD can be delivered in line with Treaty aspirations for self-determination across a people's entire life, including their death (in the long term, 3-5 years).[271]

Equity of Access

5.24 Several jurisdictions, including WA, NSW, Queensland and Tasmania, have embedded principles in their VAD Acts providing for equity of access to VAD for residents of regional and remote areas. These principles do not create specific legal obligations. However, they guide the interpretation of the VAD Acts.

5.25 Some jurisdictions have expressly included consideration of this principles as part of the annual reports the responsible Minister must table in Parliament on the use of VAD. For example, NSW requires that the review of the operation of its VAD Act must consider the principle that "a person who is a regional resident is entitled to the same level of access to voluntary assisted dying and high-quality care and treatment, including palliative care and treatment, as a person who lives in a metropolitan region".[272]

[271] Karabena Consulting, *Victoria First Peoples' Consultation: Five-year review of the operation of the Voluntary Assisted Dying Act 2017* (Appendix 5) (2022).
[272] *Voluntary Assisted Dying Act 2022* (NSW), s 186(2)(b).

Evidence before the Committee

Cultural safety

5.26 The Committee received evidence from several Aboriginal health agencies on VAD highlighting the need for cultural sensitivity and cultural safety. Urarpuntja Health Service, Utopia advised that:

> We acknowledge that this is a deeply sensitive issue and that views differ widely across Aboriginal communities. While Urapuntja Health Service does not adopt a formal position for or against VAD, we support the right of Aboriginal people to make culturally safe and informed decisions about their care, including end-of-life options, providing any legislative framework respects cultural protocols, kinship decision-making and the unique context of remote life and death…
>
> Death and dying are not solely clinical processes, they are spiritual and communal. Any legislation must respect this.[273]

5.27 The Central Australian Aboriginal Congress emphasised the need for Aboriginal Territorians to be consulted in the design of any potential legislation and the rights of services or individual clinicians to not participate in VAD be enshrined in any NT VAD law.[274]

5.28 AMSANT, the peak Aboriginal health agency, advocates for culturally safe, equitable and community-led health systems. It identified the need for a robust cultural governance structure and the inclusion of non-clinical perspectives in any future legislative or service design process.[275]

5.29 Mayor of Maningrida, James Woods, explained to the Committee the importance of cultural safety in the context of VAD and the need for it to be included as a guiding principle in the legislation:

> There is no guiding cultural safety principles built into that legislation. In the other Australian states and territories, consideration may be given whether cultural safety should be a guiding principle in the Act. That could benefit this legislation.
>
> …
>
> …consideration regarding cultural safety is a big issue for the community. Also the individual, as in family through our kinships and family ties, in regarding that decision-making, if they wanted assistance—big decisions are always made by the family…
>
> Regarding past experience about the healthcare system, it is going to be challenging. You will need to have that trust with the existing services that are currently in play.
>
> You got to remember, like we said before, that the language and communication barriers is going to be a big turning point regarding resource[ing] the operation of this, if it does roll out. You got to have that balance between cross-cultural communication as well.
>
> The community members—there can be a lot of different understandings of illness and dying that they need to interpret and understand what that means about this whole process. Yes, it is going to be a big decision for community in whole,

[273] Submission 22.
[274] Submission 300.
[275] Submission 403.

> especially somewhere like Maningrida, where there is a lot of population compared to a smaller remote community where this could be an option for them, being on a smaller scale compared to somewhere like Maningrida where it is on a big scale. There are a lot of considerations that need to come into play. That is to address the whole cultural safety issues…
>
> In best practice in cultural safety, Maningrida goes on a lot about cultural practices, and there is a lot of public policies that do not address public cultural practice. That is what we are talking about here. That is your big barrier right there. In your policies, the policy-makers need to understand how to do best practice.[276]

Equity of access

5.30 Some stakeholders to the Inquiry suggested the legislation should include an equity of access principle.[277] Mental Health Association of Central Australia (MHACA) stated:

> Considering the number of people living remotely in the NT, MHACA supports equity of access principles to be embedded in a NT VAD Act.
>
> MHACA strongly supports 2024 Expert Panel Recommendation 6 'The process for addressing Aboriginal and Torres Strait Islander cultural safety issues needs to be designed and resourced as a core part of the operationalisation of VAD.[278]

5.31 Dying with Dignity Victoria similarly told the Committee:

> We note that Western Australia, Queensland, Tasmania and New South Wales have embedded in their legislation principles providing for equity of access to VAD for residents of regional and remote areas.
>
> Similar principles may be considered to guide the interpretation of the NT's VAD legislation. However, we acknowledge the particular challenges in realising equity of access in a jurisdiction the size of the NT with a thinly distributed population across poorly serviced remote locations. Ensuring that all Territorians have the same access to VAD services as those living in major towns will require a suitably adapted model of VAD delivery with adequate funding.[279]

Committee comments

5.32 The Committee recognises the merits of a principles-based legislative design. The Committee considers it appropriate to align with other jurisdictions with regard to their guiding principles, noting that those principles stem from common law, legislation and international conventions. In particular, the Committee recognises that equitable access to VAD for remote and regional communities is a critical principle of VAD legislation present in other jurisdictions.

5.33 The importance of cultural safety of Aboriginal and Torres Strait Islander people has been highlighted in evidence to this Inquiry. In this regard, the Committee considers that it is of critical importance that cultural safety is reflected in the principles guiding VAD legislation in the NT. The Committee similarly heard that equity of access is a key issue for Territorians, ensuring that access to VAD is equally available in urban, regional or remote areas.

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[276] Meeting with community representatives of Maningrida, Darwin, 25 August 2025.
[277] Submissions 4, 23, 25, 41.
[278] Submission 25.
[279] Submission 125.

5.34 A robust VAD system must also be underpinned by high quality healthcare and palliative care services. These intersecting principles, of prominence in the NT, are explored in Chapter 2.

Recommendation 6

The Committee recommends that the principles that underpin the proposed legislation are:

- **a. Every human life is of fundamental importance;**
- **b. A person's autonomy, including autonomy in relation to informed end-of-life choices, should be respected;**
- **c. A person's decision to include chosen others in decision-making about end-of-life choices should be respected;**
- **d. A person should be supported in making informed decisions about end-of-life choices;**
- **e. A person approaching the end of life should be provided with high quality care and treatment, including palliative care and treatment, to minimise the person's suffering and maximise the person's quality of life;**
- **f. A therapeutic relationship between a person and the person's registered health practitioner should, wherever possible, be supported and maintained;**
- **g. A person should be protected from coercion and exploitation;**
- **h. Access to voluntary assisted dying and other end-of-life choices should be available regardless of where a person lives in the Northern Territory;**
- **i. A person should be supported in conversations with the person's registered health practitioner, members of the person's family and carers and community about treatment and care preferences;**
- **j. All persons, including registered health practitioners, have the right to be shown respect for their culture, religion, beliefs, values and personal characteristics; and**
- **k. A person has the right to cultural safety in relation to VAD, other end-of-life care, and healthcare in general.**

Terminology

5.35 The 2024 Expert Panel Report did not make any specific recommendation in relation to the NT legislation clarifying that VAD is not suicide. However, it did assert that the concepts were different:

> VAD is the use of a prescribed substance to cause the death of a person with a terminal illness at their request… It is not suicide.[280]

[280] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 18.

Approaches in other jurisdictions

5.36 In all Australian States and the ACT, the legislation protects authorised health practitioners who provide VAD in accordance with the Act, and also protects others (including other health practitioners, family, or carers) who assist or facilitate a request for VAD. VAD laws note that a person who dies from VAD is considered not to have died by suicide, but to have died by their medical condition.[281]

Evidence before the Committee

5.37 The Committee received mixed opinions on what terminology should be used to refer to a VAD death. Some submissions suggested that VAD is euphemistic, and the term should instead be 'assisted suicide'.[282]

5.38 Other submissions raised that the legislation should align with all other jurisdictions in Australia by stating that VAD is not suicide.[283] Some stakeholders noted this would help ensure that VAD would not impact on insurance or other legal issues after death. The Clem Jones Group stated:

> VAD laws in all states and the ACT, apart from Victoria's VAD Act explicitly declare that VAD is never to be regarded as suicide... The inclusion of this clear declaration in legislation not only represents a statement of fact, but also helps ensure VAD does not adversely impact or nullify life, health, or funeral insurance policies of a person whose death occurs as a result of the proper and legal administration of a VAD substance and that any such death is not deemed to be a "reportable death" needing coronial investigation. That provision should be included in any NT VAD law.[284]

5.39 Some stakeholders noted that the clarification that VAD is not suicide would help to remove stigma and misinformation around end-of-life choices. The Australian Psychological Society (APS) similarly stated:

> The APS also suggests that the NT clarify within their legislation that VAD is not suicide, noting this provision in all other Australian jurisdictions with VAD legislation, except Victoria … Clarifying that VAD is not synonymous with suicide helps to address the stigma and misinformation surrounding suicide and end-of-life choices and fosters more informed and compassionate understanding in society about these matters.[285]

Committee comments

5.40 The Committee notes that clarifying that VAD is not suicide can help to remove stigma and misinformation and provide certainty around legal issues after a person has died. In light of this, the Committee finds that the NT should align with the Australian model of VAD in specifying in the legislation that VAD is not suicide.

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[281] See, for example, *Voluntary Assisted Dying 2024* (ACT), s 8; *Voluntary Assisted Dying 2021* (Qld), s 8.
[282] Submissions 19, 334.
[283] Submissions 56, 161, 168.
[284] Submission 161.
[285] Submission 168.

Recommendation 7

The Committee recommends that the legislation should provide that, for the purposes of the law of the NT, a person who dies following the administration of a VAD Substance in accordance with the legislation does not:

a. Die by suicide; and

b. Is taken to have died by the disease, illness or medical condition that made them eligible to access VAD.

6 Eligibility requirements

Overview

6.1 'Eligibility' refers to the criteria that determines whether a person can access VAD. Typically, a person must meet all these criteria if they want to access VAD. This Chapter discusses five possible eligibility criteria for accessing VAD in the NT, including residency, age, medical condition, capacity and voluntariness. Excluded conditions are also discussed.

6.2 The Committee supports the 2024 Expert Panel Report's recommendation that eligibility criteria for VAD in the NT should broadly be consistent with those in other Australian states and territories, unless the conditions in the Territory require a different response.[286] The Committee recommends departing from the 'Australian model' of eligibility criteria only in relation to the timeframe to death.[287]

Voluntariness

6.3 Voluntariness refers to a person's autonomy to choose VAD without coercion from another person. The Committee notes that the 2024 Expert Panel Report did not make a specific recommendation to include voluntariness as a criterion of eligibility for VAD. However, one of the eligibility criteria under the *Rights of the Terminally Ill 1995* (ROTI Act) was that the person's decision to request VAD was made freely, voluntarily and after due consideration.

6.4 In many Aboriginal and Torres Strait Islander cultures, decision-making is made collectively through kinship networks (see Chapter 2).[288] The 2024 Expert Panel Report recognised that culturally safe kinship decision-making should be accommodated and that concerns about coercion should be balanced against a person's request for family involvement.[289] The Committee notes that this raises difficult issues for evaluating whether a person's decision is voluntary. The 2024 Expert Panel Report noted that a person may freely and voluntarily choose to request decisions about medical treatment and access to VAD be made by family members on the person's behalf.

Approaches in other jurisdictions

6.5 In all other Australian jurisdictions except Victoria, one of the eligibility criteria is that a person is acting voluntarily, and without coercion in making a request for VAD. This criterion reinforces the foundational principle that access to VAD must be entirely voluntary.

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[286] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p 56.
[287] K. Waller et al, 'Voluntary Assisted Dying in Australia: A Comparative and Critical Analysis of State Laws', 46(4) *University of New South Wales Law Journal* 1421 (2023).
[288] S. Lewis et al., 'First Nations Perspectives in Law-Making About Voluntary Assisted Dying'. *Journal of Law and Medicine*, 29(4) (2022).
[289] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 126.

Evidence before the Committee

6.6 Many stakeholders supported the explicit inclusion of voluntariness as a criterion for accessing VAD. These stakeholders emphasised the right of individuals to make their own end-of-life decisions.[290] Other stakeholders expressed concerns about the necessity to protect vulnerable populations from direct and indirect coercion.[291] This included concerns about:

- elder abuse;[292]
- inheritance impatience;[293]
- bullying and harassment;[294]
- sex-based risks;[295] and
- abuse of people with disabilities or mental illness.[296]

6.7 Consistent with the 2024 Expert Panel Report, the Committee received evidence about the complex interplay between individual choice and collective decision-making in Aboriginal cultures.[297] Many stakeholders highlighted the importance of ensuring requirements for voluntariness are culturally appropriate and allow for kinship decision-making structures.[298] The Northern Territory Public Guardian and Trustee stated:

> Aboriginal kinship systems and collective decision-making often contrast with VAD's focus on individual autonomy. Major decisions are traditionally made with family, Elders and community input, while VAD laws prioritise individual decision-making free from external influence. This tension requires balancing respect for collective practices with safeguards against coercion.[299]

6.8 The Committee heard that kinship decision-making is complex and diverse across communities and cultures. Some residents of remote communities explained the decision-making process in their communities, including the roles of various decision-makers.[300] For example, one community pointed to the important role of junggayi (bosses) as decision-makers.[301] Another community described a system of three decision-makers that would be involved in a VAD decision:

> The most complicated part is when a family member is asked to sign an application to identify that they are family for that person because when they call the hospital they say, 'You will have to identify yourself if you are the child of this person to make their decision'. A lot of our families are like that.

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[290] Meeting with community representatives of Maningrida in Darwin, 25 August 2025; Meeting with Barkly Regional Council, Tennant Creek, 27 August 2025.
[291] Submissions 18, 81, 90.
[292] Submissions 18, 147, 40, 79, 151, 81, 154, 174, 333, 334; Meeting with community representatives, Numbulwar, 26 August 2025.
[293] Submissions 209, 234, 238.
[294] Submission 90.
[295] Submission 397.
[296] Submission 81; Meeting with community representatives, Numbulwar, 26 August 2025.
[297] Submission 22; Meeting with community representatives, Barunga, 12 August 2025.
[298] Meeting with community representatives of Maningrida, Darwin, 25 August 2025.
[299] Submission 208.
[300] Meetings with community representatives, Barunga, Borroloola, Ngukurr, Maningrida and Wurrumiyanga.
[301] Meeting with Mabunji Aboriginal Resource Indigenous Corporation, Borroloola, 7 August 2025.

...

> For us, that is why they say no because they have to go through that system. It is not one person's decision, but three. They are not only three people; there is like 10 people, and they have to go through that system.[302]

6.9 In Ngukurr, a community member explained the involvement of family in medical decision-making:

> In our culture...I tell the doctor, 'I am going to speak to my families'. There is a procedure for us to talk to our families. I am not going to make that agreement or that story. I have to ask my husband, my family, my children and siblings. It is a family thing.[303]

6.10 A fellow community member pointed to the complexities of defining family in the process of medical decision-making:

> It is up to individual families, of what, it is their choice, but then you gotta see other people too as well, that are related, because we come from a big family tree and we are all related to our culture and stuff.[304]

6.11 The Committee was informed that VAD legislation would need to account for the complexity and diversity of these processes. In Borroloola, Brian Hume, Deputy Chairperson of Mabunji Aboriginal Resource Indigenous Corporation, stated:

> It is up to the individual. It is their choice, but it also collides with cultural side of things. That is what makes it very hard...No one community is the same. There are difficult dialects; different ways of doing things. This is a very sensitive issue, so it is different for each individual. I guess it is up to the individual—and the family if they are agreeable. It is... very complicated.[305]

6.12 Tessa Snowdon, AMSANT, pointed to the complexities of cultural protocols, noting:

> Certain levels of cultural protocols we will never know, and people will not feel comfortable sharing them with western systems, and we need to recognise that.[306]

Committee comments

6.13 The Committee recognises the importance of individual choice with regard to end-of-life decisions and ensuring a person is not subject to undue influence or coercion when choosing VAD. The Committee notes that the 2024 Expert Panel Report did not specifically recommend a criterion for voluntariness. However, in light of Territorians' concerns about preventing coercion and to ensure consistency with other Australian jurisdictions, the Committee considers that the legislation should expressly require voluntariness.

6.14 Whilst recognising the necessity to guard against coercion and abuse, the Committee notes many Territorians may wish to involve other people in making decisions about VAD. The Committee notes that this may include family members, cultural decision-makers, or any other person they choose. The Committee considers that a person

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[302] Meeting with St Matthew's Anglican Church, Ngukurr, 6 August 2025
[303] Meeting with St Matthew's Anglican Church, Ngukurr, 6 August 2025
[304] Meeting with community representatives, Numbulwar, 26 August 2025.
[305] Meeting with Mabunji Aboriginal Resource Indigenous Corporation, Borroloola, 7 August 2025.
[306] Aboriginal Medical Services Alliance NT, Public Hearing, Darwin, 5 August 2025.

should be able to request another person to be involved in the VAD decision. The Committee notes that this is consistent with discussions in the 2024 Expert Panel Report.

6.15 The Committee recognises that VAD legislation must be sufficiently flexible to account for the complexity and diversity of kinship decision-making structures. In this regard, the Committee does not consider it appropriate to be prescriptive about who a person may voluntarily request to be involved in the decision-making process. Instead, the Committee considers that this should be a choice for each individual.

6.16 The Committee notes the inclusion of communal methods of decision-making may raise difficult issues for evaluating whether a person's decision is voluntary. Guidelines relating to ensuring VAD is a person's voluntary choice in the context of family or kinship decision-making should be included in the Territory's formal Clinical Guidance.

6.17 The Committee notes that the legislative drafters will need to consider how the provisions regarding voluntariness interact with the requirements for VAD requests (see Chapter 7).

Recommendation 8

The Committee recommends that the legislation should provide that:

a. To be eligible for VAD in the NT, a person must be acting voluntarily and without coercion.

b. A person may voluntarily request family members or other culturally important decision-makers to be involved in making a VAD decision in accordance with culturally accepted practices of decision-making.

Medical condition

6.18 Across Australia, the medical conditions that make a person eligible for VAD are generally similar but with some notable variations, including variations regarding the prognosis timeframe and the definition of suffering. The most common eligible conditions of people accessing VAD have been cancer, neurological/ neurodegenerative diseases, and respiratory diseases.[307] The 2024 Expert Panel Report proposed that the NT generally follow the approach in other Australian jurisdictions. It recommended that:

- to access VAD in the NT, a person should have a serious and incurable condition which is causing intolerable and enduring suffering that cannot be relieved in a manner they feel is acceptable; and

[307] Tasmanian Government, *Voluntary Assisted Dying Commission Annual Report 2022-23* (2023), p. 14; WA Department of Health, *Voluntary Assisted Dying Board Western Australia Annual Report 2023-24* (2024), p. 22; Queensland Government, *Queensland Voluntary Assisted Dying Review Board Annual Report 2023-24* (2024), p. 13; NSW Government, *NSW Voluntary Assisted Dying Board Annual Report 2023-24* (2024), p. 6.

- VAD eligibility should be based on a prognosis of 12-months at the time of being assessed, irrespective of diagnosis and if the patient meets all other requirements.[308]

Approaches in other jurisdictions

6.19 Eligible conditions are clearly defined in the VAD Acts of each jurisdiction. Whilst there are some differences between jurisdictions, in general, a person has an eligible condition if they are diagnosed with at least one disease, illness or medical condition that is:

- advanced, progressive and will cause death;
- expected to cause death within 6 or 12 months (known as prognosis); and
- causing suffering that cannot be relieved in a way considered tolerable by the person.[309]

Advanced, progressive and will cause death

6.20 To be eligible for VAD, all jurisdictions require a person to have an advanced and progressive condition that will cause death, excluding Tasmania which does not require the condition to be progressive.[310] SA, Victoria and Tasmania also require the condition to be incurable, and Tasmania requires the condition to be irreversible.[311]

The Tasmanian legislation defines this subjectively by referring to a condition that is not able to be cured or reversed by treatments that are acceptable to the person. This was also the position taken in the ROTI Act.[312] In Victoria and SA, the meaning of 'incurable' is not defined. Statements by the Victorian Health Minister at the time suggest that it should be understood objectively to mean that there are no curative medical treatments available.[313] These requirements reflect the conception of VAD as another end-of-life option for people who are already dying.

6.21 In some international jurisdictions, VAD is granted based on the seriousness of the condition and the level of suffering rather than requirements for the condition to be incurable, advanced or progressive.[314] In Canada, the phrase used is a 'serious and incurable' condition.

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[308] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), Recommendation 10.
[309] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), pp. 57-58.
[310] End of Life Law in Australia, *Voluntary Assisted Dying* (2025), https://end-of-life.qut.edu.au/assisteddying.
[311] End of Life Law in Australia, *Voluntary Assisted Dying* (2025), https://end-of-life.qut.edu.au/assisteddying.
[312] *Rights of the Terminally Ill Act 1995* (NT), s 7(1)(b)(ii).
[313] B. White et al, 'Comparative and Critical Analysis of Key Eligibility Criteria for Voluntary Assisted Dying under Five Legal Frameworks' (2021), *University of New South Wales Law Journal* 44(4).
[314] *Belgian Euthanasia Act 2002*, Article 3, § 1; *Luxembourg Law on Euthanasia and Assisted Suicide 2009*, Article 2 ss 1(3), 4(3); *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001*, s 2(1)(b); *Canada Criminal Code*, RSC 1985, c C46, s 241.2(1)(c), (2).

Prognosis timeframe

6.22 In all Australian states, a person can only access VAD if a medical practitioner expects them to die within 12 months in the case of a neurodegenerative disease or within 6 months for other conditions, except Queensland which requires 12 months for all conditions.

6.23 In most Australian states, the VAD legislation initially proposed that a person should be able to request VAD if their death is expected to occur within 12 months. The 2024 Expert Panel Report observed that the shorter 6-month timeframe to death for physical conditions in most states was a result of political compromise during the parliamentary process.[315] If a person is assessed for eligibility and they are not expected to die within that timeframe, they are not prevented from requesting another assessment in the future if their condition worsens.

6.24 The Committee notes that the ACT requires a person to be approaching the end of their life but "a person can be approaching the end of their life even if it is uncertain whether their conditions will cause death within the next 12 months".[316] This is consistent with other international jurisdictions (Belgium, Luxembourg, the Netherlands and Canada) where VAD eligibility does not include a prescribed timeframe for death.[317]

Suffering

6.25 In all Australian jurisdictions, the existence of, and level of, suffering is subjectively determined by the person. VAD legislation in some jurisdictions stipulates that the person's medical condition must be the cause of the person's suffering. In Queensland, Tasmania and the ACT, the legislation expressly includes suffering caused by treatment for the person's medical condition.

6.26 The ACT specifies that suffering may be physical or mental. Both the ACT and Tasmania specify that suffering can also be caused by anticipation of future suffering.[318]

Evidence before the Committee

Advanced, progressive and will cause death

6.27 A number of submissions were explicitly supportive of the eligibility criteria requiring that a person's condition should be advanced, progressive and will cause death.[319] Some submissions used variations of the language used in other jurisdictions such as

[315] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 58.
[316] *Voluntary Assisted Dying Act 2024* (ACT), s 11(1)(b).
[317] Queensland Law Reform Commission, *A legal framework for voluntary assisted dying* (2021), pp. 88-89.
[318] *End of Life Choices (Voluntary Assisted Dying) Act* 2021 (Tas), s 14; *Voluntary Assisted Dying Act 2024* (ACT), s 11(4).
[319] Submissions 91, 96, 168.

requirements for a terminal illness or suggestion to adopt Tasmania's requirements of an "advanced, incurable and irreversible" condition.[320]

6.28 Refer to the section on 'Excluded conditions' below for further discussion on evidence received by the Committee advocating for expansion of the criteria.

Prognosis timeframe

6.29 Various submissions raised that eligibility requirements should align with other jurisdictions which would include a 12 or 6-month prognosis timeframe.[321]

6.30 Dr Chris Anderson, Specialist Doctor Palliative Care at the Alice Springs Hospital, disagreed with removal of a prognosis timeframe on the basis that it could lead to VAD on the basis of disability, with a preference to only administer VAD for someone at the end of their life:

> I have been watching what is happening in Canada where they have sort of got a process that is not anchored in a prognosis; and I think that opens the door to actually euthanasia for people on the basis of disability and I am not sure if we are ready for that in Australia. Ethically I am not ready for it. It may well be where our society ends up, but to me it is huge change, it's a huge thing. I would like to know that if we are talking about administering something to end someone's life; it is for someone who is already in that process of that road.[322]

6.31 Many submissions proposed that there should be no prognosis timeframe requirement.[323] Reasons for this included that prognosis timeframes are well-documented to be imprecise and inaccurate, and that the other eligibility criteria provide sufficient limitations and safeguards.[324]

6.32 Retired Clinical Psychologist and former Vice President of Dying with Dignity Tasmania, Robyn Maggs, additionally noted that there may be instances where doctors are unwilling to provide a prognosis timeframe:

> VAD practitioners and Care Navigators refer to its inaccuracy, with different doctors providing different advice on the same person's prognosis, or no advice at all. The prognosis is seen to have improved accuracy only for a person with weeks or years to live; with a prognosis between weeks and years consistently being shown to be unreliable, and an unreliable safeguard. In some states many people report that their doctor will not provide a prognosis, so they believe they are not eligible for VAD; others report that the advice on the time left to live was vastly different from the experience of their loved one. VAD legislation has other more reliable and medically-based criteria which allow an assessing VAD practitioner to confidently assess that the person has a disease, illness or medical condition which will cause their death. Repeal of the prognosis (predicted life left) criterion would leave the remaining eligibility criteria, which would be wholly adequate.[325]

[320] Submissions 27, 33.
[321] Submissions 3, 22, 25, 69, 72.
[322] Meeting with Alice Springs Hospital Palliative Care team, Alice Springs, 21 August 2025.
[323] Submissions 23, 33, 35, 161, 220, 378.
[324] Submissions 35, 220, 71.
[325] Submission 58.

6.33 Some submissions noted the requirement for a timeframe may result in individuals experiencing extreme intolerable suffering despite meeting all other eligibility requirements.[326] S Stephens stated:

> …arbitrary eligibility criteria, such as requiring a person to be within 6 or 12 months of death, are unnecessarily restrictive. If a person is suffering from a terminal illness with no hope of recovery, they should have the right to decide when their suffering becomes intolerable. Waiting for the so-called "final stages" only prolongs suffering and denies them control over their final moments.[327]

Suffering

6.34 Generally, submissions that referred to the definition of suffering were supportive of a wide definition inclusive of physical and psychological suffering that is determined based on the person's judgement and of 'anticipatory' suffering.[328]

6.35 Dying with Dignity New South Wales stated:

> On the question of the definition of suffering, we believe it is arbitrary to exclude psychological and existential suffering. The distinction between these kinds of suffering and so-called physical suffering is ill-defined, so it is the patient who decides if their suffering, of whatever kind, is intolerable or unbearable. If there are eligibility conditions that recognise physical suffering but do not recognise psychological and existential suffering, this will require doctors to decide the kind of suffering the patient has and whether the patient is suffering enough, a situation that may deter physicians from participating.
>
> …
>
> An individual is suffering intolerably in relation to their relevant conditions if persistent suffering (whether physical, mental or both) that is, in the opinion of the person, intolerable is being caused to them by:
>
> i) One or more of their conditions or combination of them, and/or the treatment they have received, or
>
> ii) The anticipation or expectation, based on medical advice of suffering that might be caused by any of the above, or
>
> iii) A medical complication that will or might result from any of the above.
>
> Such a nuanced definition of suffering can include cases, for example, of extreme aged frailty, where a person is completely helpless and has multiple conditions, that by themselves, are not fatal, but when added together, result in an existence of utter misery and futility. It also includes those extremely debilitating neurodegenerative diseases where a person can be unable to move their limbs, unable to breathe unaided, have difficulty swallowing and talking and be totally dependent on 24-hour care. They may spend several years in what they consider intolerable suffering and from which there is no prospect of anything except a slow painful decline.[329]

[326] Submissions 33, 22, 203.
[327] Submission 23.
[328] Submissions 35, 53, 91, 101, 321.
[329] Submission 321.

Committee comments

6.36 The Committee notes that the 2024 Expert Panel Report Recommendation 10 refers to a 'serious and incurable' condition. This reflects the language used in the Canadian VAD legislation rather than the Australian states and territories.

6.37 The Committee finds that if a person is required to be diagnosed with a condition that is advanced and progressing towards an expected death to access VAD, it is not necessary to also state that the person's condition be 'incurable'. This would introduce additional complications about whether incurability should be medically determined, or determined by reference to treatments the person finds acceptable.

6.38 Therefore, the Committee determines that, to be consistent with other Australian jurisdictions, the NT should require a person to be suffering from a condition that is advanced, progressive and expected to cause death.

6.39 The Committee is of the view that the definition of suffering should align with the ACT in that it should explicitly include mental or physical suffering, and that it should include suffering that is actual or anticipatory and caused by the person's condition or treatment for the person's condition, as is the case in the ACT and Tasmania.

6.40 The Committee notes the evidence stating that it can be difficult for medical practitioners to reliably estimate a person's prognosis outside of a narrow window of days or weeks. The Committee concludes that the requirement that a person's condition be 'advanced, progressive and expected to cause death' constitute sufficient safeguards. For these reasons, it concluded that the additional requirement of a specific timeframe to death is not required.

Recommendation 9

The Committee recommends that, to be consistent with established Australian eligibility frameworks, the legislation should provide that:

a. To access VAD in the NT, a person must have an advanced and progressive condition which is expected to cause death;

b. The person's medical condition, or treatment for that condition, must be causing intolerable and enduring suffering (physical, mental or both) that cannot be relieved in a manner the person feels is acceptable; and

c. Suffering can also be caused by anticipation or expectation, based on medical advice, of future treatment or the progression of the medical condition.

Residency

6.41 The 2024 Expert Panel Report recommended that to access VAD in the NT, a person must meet certain residency requirements, including a national residency requirement and a domestic residency requirement, with certain exceptions. The Committee supports Recommendation 8 of the Expert Panel.[330]

[330] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), Recommendation 8.

Australian residency

6.42 The Expert Panel recommended that, to access VAD in the NT, a person should ordinarily have resided in Australia for two years. The Expert Panel noted that the requirement of Australian citizenship or permanent residency has resulted in findings of ineligibility for some long-term Australian residents. The Expert Panel Report sought to address this issue by not restricting eligibility to Australian citizens or permanent residents but instead requiring only that a person has resided in Australia for two years before accessing VAD.

6.43 This streamlined Australian residency criterion is intended to effectively prevent 'VAD tourism', where residents of countries where VAD is not legal travel to countries where it is legal to access the service. It would also avoid some of the hardships which have been caused by the permanent residency criterion in state VAD legislation for long-term Australian residents who have not formally received permanent resident status.

Territory residency

6.44 The 2024 Expert Panel Report noted that the NT is the only jurisdiction in Australia which does not currently have a VAD law. It therefore observed that there does not appear to be a compelling need for a domestic residency requirement. There is some unresolved tension within the Report, however, because the Expert Panel recommended that a person should reside in the Territory for 12 months before being eligible to access VAD.

6.45 The Committee notes that a 12-month domestic residency requirement will exclude new residents of the NT who receive a terminal diagnosis after moving to the Territory from accessing VAD. It could also introduce complications for Territorians who live a nomadic lifestyle for work or personal reasons. These issues can be ameliorated by the inclusion of exceptions.

Exceptions

6.46 The 2024 Expert Panel Report recommended two exceptions from the domestic residency requirement. The first exception is to allow a person who is not a resident in the NT, but lives in a community close to the NT border, to access VAD in the Territory. If the Territory residence requirement is retained, this exception will provide flexibility for residents of border communities, who may be closer to a town or medical services in the NT than in their home state. If the Territory residence requirement is not included, this exception becomes unnecessary to include.

6.47 The second exception is for persons with family, cultural, or support links to the NT. This exception may be relevant to both the Australian residence and Territory residence requirement.

6.48 The Committee believes that consideration should also be given to people with a long-standing association with, or connection to, the NT.

Approaches in other jurisdictions

6.49 All Australian jurisdictions have a requirement for residency. There are two aspects to this requirement. A person accessing VAD must have:

- Australian citizenship or residency; and
- Residency in the State or Territory in which the VAD legislation operates.

6.50 The two-year Australian residency requirement is broadly consistent with the legislation in Queensland, Tasmania and NSW, which allows persons who have been resident in Australia for at least three years to request access to VAD.[331]

6.51 All Australian states also allow a person who is an Australian citizen to access VAD. This alternative allows an Australian who is not currently living in Australia to return home to family after being diagnosed with a terminal illness, and be eligible to access VAD.

6.52 All other jurisdictions have a domestic residency requirement. Some jurisdictions have developed exemptions to residency requirements. For example, the ACT, NSW and Queensland enable a person to apply for an exemption to the local residency requirements if they have a 'close' or 'substantial' connection to the State or Territory.[332] For example, the person may live in a border community or work or receive medical treatment in the State or Territory. Exemptions may also extend to people with local family or former residents whose families reside in the State or Territory. There are also compassionate grounds for granting exemptions.

6.53 Some jurisdictions establish specific exemptions from residency requirements for Aboriginal and Torres Strait Islander people. For example, the ACT will consider exemptions for Aboriginal or Torres Strait Islander individuals with substantial connections with the ACT community who wish to finish up on Country.[333]

Evidence before the Committee

6.54 Many stakeholders echoed the views of the 2024 Expert Panel Report for the Australian residency requirement to be more permissive.[334] The Western Australian (WA) VAD Review Board pointed to recommendations that have been made for amendments to the *Voluntary Assisted Dying Act 2019* (WA) in their Annual Reports covering the first three years of operation in WA. The WA Review Board recommended amendments to expand access to voluntary assisted dying for long-term Australian residents who are not an Australian citizen or permanent resident and provide an exemption pathway to the ordinary residency requirements for people who have a substantial connection to WA or have been found eligible in another Australian jurisdiction.[335]

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[331] *Voluntary Assisted Dying Act 2022* (NSW), s 16(1)(b)(iii); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas), s 11(1)(a)(iii); *Voluntary Assisted Dying Act 2021* (Qld), s 10(1)(e)(iii).
[332] *Voluntary Assisted Dying Act 2022* (NSW), s 17; *Voluntary Assisted Dying Act 2021* (Qld), s 12; *Voluntary Assisted Dying Act 2024* (ACT), s 154.
[333] *Voluntary Assisted Dying Act 2024* (ACT), s 154.
[334] Submissions 203, 172, 321.
[335] Submission 172.

6.55 This view was supported by Go Gentle Australia which advocated for expanded Australian residency requirements to capture long-term residents of Australia and those who ordinarily reside in Australia on different visa classes (i.e., Working and Skilled Visa holders, New Zealand citizens).[336]

6.56 Some submitters supported the 2024 Expert Panel Report recommendation to have a domestic residency requirement.[337] Largely, these views were informed by concerns that the NT system may be overburdened by non-Territorians seeking VAD. The Northern Territory Voluntary Euthanasia Society stated:

> Considering the Territory's small populations, demography and corresponding small pool of medical professionals, it is recommended that a VAD regime be restricted to Territory residents. This will be of greater importance if the Territory adopts a less restrictive regime than any of the states. If no residential restrictions apply, the potential impact of interstate and international applicants needs consideration.[338]

6.57 On the other hand, many stakeholders supported not having a Territory-specific residency requirement. Go Gentle Australia stated:

> Residency requirements were first incorporated into legislation to preclude residents of other states where VAD was not yet legal from travelling interstate to access an assisted death. The first states that passed VAD laws believed an influx of people could overburden health systems.
>
> However, given seven Australian jurisdictions have now legislated VAD, Go Gentle recommends the Northern Territory does not include similar local residency requirements. This is because:
>
> - Local residency requirements are another layer of bureaucracy for dying people to navigate
> - Australians with terminal illnesses should be free to move across state borders to access treatments, be closer to friends, family or carers, or simply spend their final days in the place of their choosing.
>
> If a local residency requirement is to be included, Go Gentle recommends adding an exemption, as Queensland and New South Wales have done, if the person has substantial connection to the NT. For example, currently Australians living on those states' borders are able to access VAD provided they can show a 'substantial connection' to NSW or Queensland.[339]

6.58 Likewise in their submission, the Australian Lawyers Alliance noted that domestic residency requirements are 'less critical now', noting there is VAD legislation in all Australian states and the ACT's legislation will commence soon. However, the submission stated:

> …there are considerations regarding ensuring that resources provided for and funded by the Northern Territory Government are available first and foremost to residents of the Northern Territory, and that international tourism for Voluntary Assisted Dying should be discouraged.[340]

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[336] Submission 203.
[337] Submissions 83, 84, 91,
[338] Submission 83.
[339] Submission 203.
[340] Submission 157.

6.59 Some stakeholders emphasised the importance of exemptions should the domestic residency requirement be retained. Dr John Zorbas, President of AMA NT, stated:

> There is the idea of connection to the NT that will be a bigger issue for us than other jurisdictions. There are people who may want to return to country, who have very strong spiritual connections to land and who have been living interstate for reasons. There should be a mechanism that we can assess that appropriately and make decisions around that and allow people that right of review rather than a very prescriptive rule.
>
> We have people who live in the Territory for decades and then leave because they are seeking health services elsewhere because we cannot provide the service to them. It would be a perverse disincentive to them to then deny them VAD should that treatment no longer be an option for them and they want to return to die on their terms in their homes. Special attention needs to be paid on connection.[341]

6.60 These concerns were echoed in remote communities. In Tennant Creek, the Barkly Regional Councillor, Greg Marlow noted:

> [W]e have got a nomadic or transient population. People move from community to community to community at various times of the year. As an example, they might not be at Alpurrurulam for 12 months. Because of the Wet Season they move to Mount Isa, Tennant Creek or Alice Springs. That is where you are saying you have got to have some flexibility in your legislation to take account of that.[342]

Committee comments

6.61 The Committee considers that it is important to ensure Territorians have equitable access to VAD. The Committee notes that other jurisdictions have reported unintended consequences of Australian residency requirements on long-term residents who have not formally received permanent resident or citizenship status.

6.62 The Committee recognises the importance of flexibility in residency requirements to account for individuals with connections to the NT. In this regard, the Committee notes that there may be instances in which a person is not an Australian citizen and does not reside in Australia, but has cultural, familial or support links in the NT. Therefore, the Committee considers that an exception should apply for a person who is not an Australian citizen but has formerly resided in Australia, and who has family, cultural, or support links to the NT.

6.63 Further, the Committee notes that, whilst it ultimately recommended domestic residency requirement, the Expert Panel observed that there does not appear to be a compelling need for one. Evidence given to the Committee suggests there is division amongst stakeholders on whether to include a Territory residency requirement in the legislation.

6.64 Given the Committee's recommendation that no timeframe to death be included in the NT's VAD legislation, there is a possibility that persons from Australian states where a 6 month timeframe to death applies may seek to access VAD in the NT. A requirement to have been resident in the Territory for 12 months before making a request for VAD will prevent this occurring.

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[341] Aboriginal Medical Services Alliance NT, Public Hearing, Darwin, 5 August 2025.
[342] Meeting with Barkly Regional Council and Tennant Creek Local Authority, Tennant Creek, 27 August 2025.

6.65 Consideration should also be given to people with a long-standing association with, or connection to, the NT.

Recommendation 10

The Committee recommends that the legislation should provide that:

a. To be eligible to access VAD in the NT, a person should either be an Australian citizen or have ordinarily resided in Australia for two years.

b. A person should also have been ordinarily resident in the Territory for 12 months. An exemption should apply to a person who is not resident in the NT, but lives in a community close to the NT border.

c. An exception to both the Australian citizen or resident requirement and the Territory residence requirement should apply to a person who has family, cultural, or support links to the NT. This will enable such a person to return to the Territory to access VAD in the context of their personal support networks.

Age

6.66 The discussion around establishing a minimum age requirement arises from consideration of whether individuals under 18 possess appropriate decision-making capacity in relation to VAD.[343] The 2024 Expert Panel Report recommended that, to access VAD in the NT, a person should be aged 18 years or older.[344]

Approaches in other jurisdictions

6.67 All Australian jurisdictions limit access to VAD to individuals over the age of 18. This minimum age is consistent with the legal age of adulthood in each jurisdiction.

6.68 Some international jurisdictions provide for VAD access to minors. For example, the Netherlands allows access for minors aged 12 and over.[345] Belgium does not have a minimum age requirement.[346]

6.69 Some Australian jurisdictions have considered not setting an age limit for accessing VAD.[347]

Evidence before the Committee

6.70 The majority of submissions that referred to an age requirement were supportive of the minimum age being 18 years or older.[348] Dying with Dignity NSW submitted that:

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[343] Queensland Law Reform Commission, *A legal framework for voluntary assisted dying* (2021), p. 147.
[344] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), Recommendation 9.
[345] *The Netherlands Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2001*, s 2(2).
[346] European Union Agency for Fundamental Rights, *Requesting euthanasia* (2022), https://fra.europa.eu/en/publication/2017/mapping-minimum-age-requirements-concerning-rights-child-eu/requesting-euthanasia.
[347] Legislative Assembly for the Australian Capital Territory, Select Committee on the Voluntary Assisted Dying Bill 2023, *Inquiry into the Voluntary Assisted Dying Bill 2023* (2024), p. 42.
[348] Submissions 53, 84, 91, 112, 321.

> On the question of the age, we support the minimum age for access to VAD being 18 years. We do understand that mature minors could have the capacity to make an informed decision about VAD however we believe that it is a very complex matter on which there is as yet, not a large body of evidence, and that it would be premature to allow access to minors at this time.[349]

6.71 Some submissions recommended that individuals under 18 should be able to access VAD with additional safeguards put in place. The suggested additional safeguards included parental consent,[350] consultation with an experienced counsellor or psychologist,[351] use of the Groningen Protocol,[352] development of the concept of a 'mature minor',[353] and establishment of a special tribunal with relevant expertise.[354]

6.72 Christians Supporting Choice for Voluntary Assisted Dying recommended that:

> ...if the minimum age requirement is agreed to, this could be reviewed at a later stage.[355]

Committee comments

6.73 The Committee finds that the NT approach should remain consistent with all other jurisdictions across Australia in requiring that a person must be 18 years or older to access VAD. The Committee notes this is approach also consistent with what was previously legislated under the ROTI Act and with Recommendation 9 of the 2024 Expert Panel Report.

Recommendation 11

The Committee recommends that the legislation should provide that a person must be aged 18 or over to be eligible to access VAD in the NT.

Capacity

6.74 The 2024 Expert Panel Report recommended that a person must have capacity at all stages throughout the entire VAD process.[356] This requirement is an important safeguard for the person accessing VAD and for participating health practitioners.

Approaches in other jurisdictions

6.75 The VAD legislation in other Australian jurisdictions explains the notion of decision-making capacity to clarify that it should not be narrowly construed. All Australian jurisdictions expressly state the common law presumption that a person has capacity

[349] Submission 321.
[350] Submissions 37, 83, 319.
[351] Submissions 71, 319.
[352] Submission 71.
[353] Submissions 83, 319.
[354] Submission 83.
[355] Submission 71.
[356] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p 59.

unless there is evidence to the contrary. Each jurisdiction has their own 'capacity test' for determining whether a person can make a medical decision.[357]

6.76 Most VAD laws also expressly recognise that a person's capacity may fluctuate from time to time, that a person may have capacity for some decisions but not others, and that an unwise decision is not automatic evidence of incapacity.

6.77 A majority of Australian jurisdictions (ACT, Queensland, Victoria, SA) also specify that a person can be considered to have decision-making capacity if they are able to make the decision to access VAD with adequate and appropriate supports.

6.78 The Committee notes that there may be progressive diseases, such as dementia, which may impact a person's decision-making capacity. Some countries (such as Belgium, the Netherlands and Canada) have advanced directives which allow people to consent to VAD in advance for a future time when they no longer have decision-making capacity, such as after developing dementia or another cognitive condition.[358]

6.79 However, no Australian jurisdiction has an advance directive model. The issue of using advance directive models may be considered in future reviews in other jurisdictions. For example, the ACT will consider this issue in its first review of its VAD Act in 2027.[359]

Evidence before the Committee

6.80 The Committee observed general support for needing decision-making capacity to request VAD. Many submitters emphasised the importance of presumption of decision-making capacity. The Australian Psychological Society stated:

> There should be a presumption of rationality for a person seeking access to end-of-life care, including VAD. Having a disability (e.g., cognitive or communication impairment), disease (e.g., dementia) or a mental illness (e.g., depression), or being less than 18 years of age, does not automatically render a person incapable of making an informed decision and should not automatically negate their right to access VAD. An appropriate supported decision-making framework should be available to ensure potentially vulnerable individuals can still have equitable access to VAD. We acknowledge that supported decision-making for VAD can be particularly contentious, including for the decision supporter and health professionals, thus requiring a model that carefully balances rights and protections for vulnerable individuals and those who support them. [360]

6.81 Speech Pathology Australia recommended that VAD legislation should specify that capacity assessments allow for the use of relevant supports, including communication aids and strategies. The organisation stated:

> It is often mistakenly believed, even by some medical professionals, that individuals who cannot speak lack legal capacity. In reality, there are many ways that many people with communication difficulties can demonstrate their decision-making capacity if they are properly supported. To ensure fair access for those

[357] End of Life Law Australia, *Capacity and Consent in Medical Treatment* (2025), https://end-of-life.qut.edu.au/capacity#statetercap.
[358] See for example, *Belgian Euthanasia Act 2002* art 4; *Luxembourg Law on Euthanasia and Suicide 2009*, art 4.
[359] *Voluntary Assisted Dying Act 2024* (ACT), s 162(2)(b)(iii).
[360] Submission 168.

> with progressive conditions or other communication support needs, it is essential that legislation includes explicit requirements to address these needs.[361]

6.82 Some submissions note the need for guidance on determining decision-making capacity. Many agreed that requirements for decision-making capacity should align with existing NT legislation on medical decision-making.[362] Some submitters noted there was a need for guidance on capacity assessments. The Australian Psychological Society stated:

> Determining decision-making capacity is a complex medico-legal area that addresses matters associated with balancing respect for patient autonomy with the responsibility of protecting people from harm resulting from impaired decisional capacity. VAD legislative provisions and systems in the NT need to support an expedited assessment of decision-making capacity where it is in question due to a condition or developmental considerations, or there are concerns about potential coercion. The legislation should make clear the situations requiring decision-making capacity assessment, the timeframes for assessment, and the skills and competencies of suitably qualified assessors who may be called on to provide a determination of decision-making capacity for access and implementation of VAD.[363]

6.83 Some submitters noted that decision-making capacity may fluctuate and it should not be presumed that a person lacks capacity to make decisions about VAD because they cannot make other decisions. The Northern Territory Public Guardian and Trustee noted that approaches in other jurisdictions recognise that decision-making capacity is 'decision-specific and time-specific', stating:

> This approach aligns with the current substitute decision-making legislation in the Northern Territory; *Health Care Decision Making Act 2023*, *Guardianship of Adults Act 2016* and *Advance Personal Plan Act 2013*, which all presume capacity unless evidence demonstrates otherwise. Guardianship does not necessarily equate to incapacity for all decision making, and capacity can vary depending on the nature of the decision. Consistent with other jurisdictions, eligibility should be determined by a person's decision-making capacity, not their legal status under a guardianship order. For example, a person with a guardianship order for financial matters only continues to have capacity to make decisions about their health, including VAD. This principle is particularly important given the disproportionately high rates of guardianship among Aboriginal and Torres Strait Islander peoples.[364]

6.84 Some submitters emphasised the need for capacity assessments to be culturally appropriate.[365]

6.85 A number of submissions advocated for development of VAD legislation which would enable individuals, including those with dementia, to access VAD after they have lost decision-making capacity where the person pre-approved this in their advance care directive.[366] The Northern Territory Voluntary Euthanasia Society stated:

> There is strong support in the community for a person to be able to request voluntary assisted dying in advance care planning documents, so that assisted dying could take place after the person has lost capacity. Submissions to all state

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[361] Submission 182.
[362] Submissions 157, 208.
[363] Submission 168.
[364] Submission 208.
[365] Submission 168.
[366] Submissions 6, 33, 36, 46, 111, 139.

> VAD inquiries advocated this be provided for; however no state has accepted the challenge. Our society has long accepted that doctors, in consultation with family members, can lawfully remove life support where no hope of recovery exists, without the patient's consent. One can also give an enduring power of attorney in advance care planning documents to make life critical decisions in the event competence is lost. It is time for legislators to embrace the issue and devise an acceptable regime.
>
> Reference provisions in Canadian legislation where a person with dementia has been found to be eligible for VAD, they can exercise the final consent waiver provision of the Criminal Code and make arrangements for VAD to be provided after they lose decision-making capacity.[367]

6.86 Dementia Australia highlighted the importance of discussions about dementia in the context of VAD, stating:

> We commend the Expert Advisory Panel's 2024 final report for its comprehensive consideration of the complexities surrounding dementia and access to VAD. In particular, we acknowledge the Panel's exploration of the limitations of current VAD legislation for people with dementia, the implications of progressive cognitive decline on decision-making capacity, and the need for future national discussion on dementia-inclusive VAD framework.
>
> Dementia is a progressive, life-limiting condition, and while some people with dementia retain decision-making capacity for extended periods, others may experience more rapid decline. Dementia Australia supports every person's right to make informed decisions about their care, including end-of-life options, while also emphasising the need for safeguards to protect against coercion or misuse.
>
> We encourage the Committee to discuss the issues raised by VAD with people living with dementia directly and to and consider the needs of people living with dementia to ensure that any future VAD legislation in the NT is inclusive, ethical, and respectful of individual rights and autonomy.[368]

6.87 In some remote communities, the Committee heard support for enabling people with dementia to access VAD. Staff including the CEO at Tennant Creek Mob Aboriginal Corporation, who deliver many valuable community services (Figure 11), shared their personal story regarding early hereditary early onset Alzheimer's, and the importance of people with such a disease having the option to access VAD. Jacqueline Bethel told the Committee:

> We have dedicated family members who have taken part in the Dominantly Inherited Alzheimer Network (DIAN) trial each year, and we have done that so we can eliminate the gene in the next generation. We are not coming from a place of emotion or uninformed or uneducated on the topic; we are speaking from experience and coming from a proactive place of putting in place procedures for their passing. It is unacceptable to not include Alzheimer's; we would not let a dog die like that, so that just cannot be placed in the too-hard basket—you need to go back and review that and work out what that should look like. Form an ethics committee. Form a doctors' opinions committee. There is lots of advice and expertise around that topic.[369]

[367] Submission 83.
[368] Submission 106.
[369] Meeting with Tennant Creek Mob Aboriginal Corporation, Tennant Creek, 28 August 2025.

6.88 Josephine Bethel stated:

> The dementia is an important one because the only option available to them at present, with the early onset Alzheimer's, is a DNR—do not resuscitate. That is their only option….And it is a long death, too long. They should be able to, when they still have their faculties at the beginning, when they are doing their legal wills and all that, they should then be able to do their VAD and say, 'My sister, who is my power of attorney, can say when to call it'. You know what I mean? It is still their decision.[370]

Figure 11: The Tennant Creek Mob Aboriginal Corporation's services are broad and include a youth focused night patrol, harm minimisation activities and suicide prevention program.

[370] Meeting with Tennant Creek Mob Aboriginal Corporation, Tennant Creek, 28 August 2025.

6.89 Some submissions expressed opposition to, or wariness of, this idea.[371] The 2024 Expert Panel noted concerns about patient safety, vulnerability, elder abuse and inheritance impatience among relatives. They also noted a high proportion of health practitioners reported difficulty accurately evaluating capacity in persons with dementia.[372]

6.90 The Northern Territory Public Guardian and Trustee acknowledged the complex nature of this topic but noted the potential for exploring and consulting on it further given general community openness to the idea:

> No Australian jurisdiction currently permits advance consent to VAD, maintaining the requirement that individuals retain decision-making capacity throughout the process. The Public Guardian and Trustee agrees that this approach reflects both the complexity of predicting future circumstances and values, as well as ethical concerns about irrevocable advance consent for life-ending treatments. While this is the current national position, the ACT's legislation includes a review provision indicating that advance consent will be considered as part of its scheduled 2027 review and other jurisdictions may also examine this issue in future legislative reviews.
>
> If this is introduced in the Northern Territory, the Public Guardian and Trustee would consider its inclusion reasonable from both a safeguarding and individual dignity perspective. Initial community consultation suggests an openness to exploring this option, however further engagement would be required to determine the most suitable approach bearing safeguards in mind. Preliminary discussion with clinicians are already underway, acknowledging that voluntary assisted dying will inevitably be raised by some patients as part of their planning for end-of-life and/or loss of capacity. Attempts to exclude voluntary assisted dying are impractical, as patients see end-of-life choices holistically and are unlikely to partition advance care planning from voluntary assisted dying.[373]

Committee comments

6.91 The Committee notes that a person should not be presumed to lack capacity to make end-of-life choices because they have an illness, an intellectual disability, or lack capacity for certain other choices, such as financial decisions.[374] As a result, a person should be afforded the presumption of capacity despite illness or disability, personal characteristics, capacity to make other decisions, or despite them making a decision others disagree with. Individuals should also be given the option to access appropriate supports when making the decision to access VAD. Explicit inclusion of these provisions in the legislation will ensure that individuals who may be considered vulnerable in some circumstances are protected from being unfairly discriminated against in their decision to choose VAD.

6.92 The Committee notes that allowing access to VAD by persons with dementia involves either relaxing the eligibility requirements to allow people in the early stages of

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[371] Submissions 51, 68, 159.
[372] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 128.
[373] Submission 208.
[374] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 59.

dementia to access VAD while still competent, or allowing access through an advance directive or request.

6.93 While recognising community desire in the NT for one or both of these options, the Committee preferred to align the NT framework with the Australian model and restrict access to VAD to persons who retain capacity up to the time of administration. This aligns with Recommendation 11 of the 2024 Expert Panel Report. However, the Committee understands that this is an evolving area which will be considered in other jurisdictions in the coming months and years. The Committee considers that it may be appropriate to review this criterion when the Act is reviewed (see Recommendation 80.

Recommendation 12

The Committee recommends that the legislation should provide that:

- **a. To be eligible to access VAD in the NT, a person must have decision-making capacity in relation to VAD.**
- **b. A person must have decision-making capacity in relation to VAD at all stages of the VAD process, including the First Request, Formal Request, and the Administration Decision.**
- **c. A person should be presumed to have capacity unless there is evidence to the contrary.**
- **d. A person can be considered to have decision-making capacity if they are able to make the decision to access VAD with adequate and appropriate supports.**
- **e. A person's capacity may fluctuate from time to time.**
- **f. A person should not be presumed to lack capacity in relation to VAD because:**
  - **i. they have an illness or disability, including an intellectual disability or mental illness;**
  - **ii. they lack capacity in relation to other decisions;**
  - **iii. they make a decision that others disagree with; or**
  - **iv. of a personal characteristic such as age, appearance or language skills.**

Excluded conditions

6.94 There are some conditions which make a person ineligible for VAD, and some conditions which cannot be the sole basis a person would be granted access to VAD. The main conditions that fall into this category which attract debate are mental illness, dementia and disability.

6.95 The 2024 Expert Panel Report found that persons should not be eligible for VAD solely on the basis of a diagnosis of mental illness, as mental illness is not a terminal condition. A person who has a mental illness and is otherwise eligible for VAD based

on a terminal illness (including retaining decision-making capacity) should not be excluded from accessing VAD.[375]

6.96 The 2024 Expert Panel Report did not make a recommendation to exclude persons from accessing VAD solely on the basis of a disability.

Approaches in other jurisdictions

6.97 All other Australian jurisdictions exclude persons from accessing VAD solely on the basis of a diagnosis of mental illness, disability or if they have lost decision-making capacity. All jurisdictions have protections that ensure a person who has a mental illness or disability but meet all other eligibility criteria, are not prevented from accessing VAD.[376]

6.98 People in the Netherlands, Belgium, Luxembourg, Switzerland and soon also Canada, are eligible for VAD on the sole basis of mental illness.[377] Belgium and the Netherlands also enable VAD for individuals with a disability as the sole underlying cause of suffering.[378]

6.99 Refer to the section above for further discussion on exclusion of dementia due to the requirement to have decision-making capacity at all stages during the VAD process.

Evidence before the Committee

6.100 Some submissions advocated for expanded eligibility requirements that would allow mental illness and/or disability to be the sole reason a person may choose VAD.[379] During community consultations with the Tennant Creek Mob Aboriginal Corporation, the Committee said that "we would argue that mental health is intolerable suffering".[380]

6.101 Many submissions expressed that eligibility requirements should align with other jurisdictions. This includes: a person must have a condition that will cause their death in order to be eligible for VAD; a person cannot access VAD based solely on mental illness or disability; and a person who meets all other eligibility requirements and also has a mental illness or disability is not prevented from accessing VAD.[381]

6.102 In Tennant Creek, the Committee heard from Amy James, a disability advocate who emphasised the importance of choice for people with disabilities, noting they should not experience discrimination on the basis of their disability.[382]

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[375] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 59.
[376] End of Life Law in Australia, *Voluntary Assisted Dying* (2025), https://end-of-life.qut.edu.au/assisteddying.
[377] S. van Veen et al., 'Physician assisted death for psychiatric suffering: Experiences in the Netherlands' (2022), *Frontiers in Psychiatry*, 13.
[378] T. Stainton, 'Disability, vulnerability and assisted death: commentary on Tuffrey-Wijne, Curfs, Finlay and Hollins', *BMC Medical Ethics* 89 (2019).
[379] Submissions 117, 37, 16.
[380] Meeting with Tennant Creek Mob Aboriginal Corporation, Tennant Creek, 28 August 2025.
[381] Submissions 3, 22, 25, 69, 72.
[382] Community drop-in session, Tennant Creek, 27 August 2025.

6.103 Rebecca Muller provided her opinion, as a person living with a disability, that people with a terminal illness and a disability should not be discriminated against in their request for access to VAD on the basis of their disability:

> I have seen that some people are opposed to VAD on the Basis of Protecting the Vulnerable (Disabled Elderly and Mentally ill). I have yet to see any of these people who claim to care about disabled people do anything to support us before getting to the point of considering VAD. As you know VAD is legal only for terminally ill Australians in other states. But refusing to expand VAD to include people with disabilities does not protect them from abuse I say this as a person with a disability who is well looked after by my parents but not at all by the systems or people which claim to be opposed to VAD for the benefit of people like me. People with disabilities are not stupid and we should have just as much right to end our lives at the time of our choosing. Anything else is the same discrimination VAD opponents claim to be against.[383]

6.104 Some stakeholders noted that people living with disabilities may wish to access VAD on the basis that they experience suffering. Submitter, Geoffrey Kerr Williams stated:

> There are some conditions which are not 'terminal', but which are nevertheless incurable and chronically debilitating, making life unbearable. A well-publicised British example at the time was that of the late Tony Nicklinson whose devastating stroke left him completely paralysed with Locked-in Syndrome. He could only communicate by blinking or moving his head at a computer screen. His only option was to use Voluntary Stopping of Eating and Drinking (VSED) which took weeks of pointless suffering.[384]

Committee comments

6.105 The Committee considers that it is important to ensure equity of access for all eligible people who want to access VAD. In this regard, the Committee believes a person should not experience barriers to accessing VAD on the basis of disability or mental illness.

6.106 The Committee notes the ineligibility of people who have a disability or a mental illness to access VAD on that sole basis is already implicit in the requirement that a person be suffering from a medical condition which is expected to cause death. However, the Committee decided to make this explicit for the avoidance of doubt.

6.107 The Committee acknowledges the desire expressed by some to allow individuals to access VAD on the sole basis of their mental illness or disability. The Committee observed high public interest in this issue and notes it may be considered in a subsequent review of the Act (see Chapter 12).

Recommendation 13

The Committee recommends that the legislation should provide that a person with a mental illness or a disability may be eligible for VAD, but they would not be eligible on the sole basis of a mental illness or disability.

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[383] Submission 325a.
[384] Submission 68.

7 Request and assessment process

Overview

7.1 The 2024 Expert Panel Report set out a framework for the request and assessment process for VAD. This includes requirements for:

- initiating discussions about VAD;
- making two requests, including a Formal Request in writing;
- undertaking two assessments by two independent health practitioners to determine eligibility for VAD;
- use of interpreters (where necessary) throughout the VAD request and assessment process; and
- use of telehealth for components of the VAD process.

7.2 Each step of the request and assessment process must be documented in the patient's medical record and reported to the Review Board in an approved form and within two business days of completing the step.

7.3 This chapter examines the request and assessment process.

Initiating discussions about VAD

7.4 The extent of limitations, if any, on health practitioners' ability to initiate the conversation about VAD with their patients has been a significant point of debate across Australia.

7.5 The 2024 Expert Panel Report proposed that medical practitioners should be allowed to introduce the subject of VAD services to patients during discussions about treatment options.[385] The 2024 report does not fully consider whether other healthcare workers should be allowed to introduce the topic of VAD or not.

Approaches in other jurisdictions

7.6 Each Australian jurisdiction imposes restrictions on health practitioners and/or healthcare workers raising the topic of VAD, although the nature of these restrictions varies. The Committee notes that the term 'health practitioners' specifically refers to registered health practitioners under the Health Practitioner Regulation National Law, including medical practitioners (i.e., doctors), nurses, pharmacists and Aboriginal Health Practitioners. The term 'healthcare worker' is a broader category that encompasses non-clinical, as well as clinical roles.

7.7 In Victoria, health practitioners are prohibited from mentioning VAD unless the patient brings up the subject first. Similar provisions exist in SA.[386] In WA and Queensland, a medical practitioner or nurse practitioner can initiate a discussion or

[385] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), Recommendation 12.
[386] End of Life Law in Australia, *Voluntary Assisted Dying* (2025), https://end-of-life.qut.edu.au/assisteddying.

suggest VAD to a person so long as they also inform the person, at the same time, about available treatment and palliative care options, and their likely outcomes. Registered health practitioners, or other persons who provide health or professional care services are prohibited from initiating a discussion or suggesting VAD but can provide information about VAD on a person's request.[387]

7.8 Tasmania and NSW have similar provisions, however a health practitioner or a healthcare worker who is not a medical practitioner has an additional requirement to inform the person that a medical practitioner would be the most appropriate person with whom to discuss the VAD process and care and treatment options.[388]

7.9 In all States there are no restrictions on a person providing information about the VAD process at the person's request.[389]

7.10 The ROTI Act took a similar approach to WA and Queensland, as well as requiring the practitioner to inform the patient about "counselling and psychiatric support and extraordinary measures for keeping the patient alive, that might be available".[390]

Evidence before the Committee

7.11 Some submissions stated their opposition to health practitioners and healthcare workers being able to initiate discussions about VAD.[391] However, much of the evidence expressed support for this idea, with several sources emphasising that any initial discussion about VAD should be accompanied by information on other care and treatment options, consistent with the Australian model of VAD.[392] The Committee heard this would allow for a more 'patient-centred' approach.[393] Dr John Zorbas, President of AMA NT, explained the rationale for health practitioners initiating conversations about VAD:

> As is the same with all medical care, it is unacceptable for any form of coercion or direction from the physician that is not consistent with the patient's wants and needs. It is not the physician's job to drive that conversation, but it is our job to make sure that a patient has all the options that are available to them when it comes to end-of-life care. If there are legal prohibitions about the discussion of some element of that such as VAD, then I am not able to present them with the full spectrum of what their end-of-life care options are.[394]

7.12 The Committee heard mixed views regarding who should initiate discussions about VAD in remote communities. While some stakeholders expressed caution about healthcare workers initiating discussions, others emphasised the importance of being fully informed about all available end-of-life care options, including VAD. In one remote community, an Elder expressed her support for allowing doctors to bring up

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[387] End of Life Law in Australia, *Voluntary Assisted Dying* (2025), https://end-of-life.qut.edu.au/assisteddying.
[388] *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas), s 17(3)); *Voluntary Assisted Dying Act 2022* (NSW), s 10(3)).
[389] End of Life Law in Australia, *Voluntary Assisted Dying* (2025), https://end-of-life.qut.edu.au/assisteddying.
[390] *Rights of the Terminally Ill Act 1995* (NT), s 7(e).
[391] Submissions 84, 98
[392] Submissions 71, 83, 108, 125, 161, 168, 179, 182
[393] Submission 161.
[394] Australian Medical Association NT, Public Hearing, Darwin, 5 August 2025.

the topic of VAD to patients, saying "I want the doctor to talk to me… Yes. He is giving me a choice. I have to do it".[395]

7.13 However, the Committee observed many remote healthcare workers would not feel comfortable initiating conversations about VAD due to cultural sensitivities,[396] concerns about liability,[397] and the potential of losing trust with patients.[398] In Alice Springs, the Committee heard concerns that Aboriginal Liaison Officers (ALO) would not feel comfortable speaking about VAD to clients. One ALO stated "No. I wouldn't do that… Maybe the health workers [could], I don't know".[399]

7.14 One remote aged care nurse pointed to the difficulties associated with knowledge gaps and the use of VAD terminology. They noted that this could contribute to harmful outcomes if the topic was initiated by staff:

> I think it is the word that is wrong because when you talk about VAD, then immediately you are helping to kill them. That is the perception of everybody. [400]

7.15 In Tennant Creek, the Committee heard that certain healthcare staff would not be comfortable initiating discussions about VAD, but noted that individual institutions would need to develop an organised approach to dealing with VAD discussions:

> …I would find someone who is actually comfortable doing that… That would be okay as long as that other person is comfortable. You have got to be comfortable because afterwards you have got to live with yourself.[401]

7.16 There was significant debate about which health professionals should be permitted to raise VAD with patients. Some stakeholders suggested the rights and obligations of initiating VAD discussions should extend to other health professionals and not just doctors.

7.17 NT Health recommended that the NT legislation should specify that all health practitioners should be able to initiate conversations about VAD (i.e., not just doctors) as long as they have received appropriate training. This is to ensure that comprehensive health information is given to the patient. NT Health stated:

> The rationale for this modification is critical to the NT context due to its multidisciplinary workforce and very limited access to medical practitioners, especially in remote areas. Removing this stipulation addresses a potential access barrier. A debate over this 'gag clause' is outlined in the 'Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024' as a 'troubling barrier to people's right to know the full range of care and treatment options.' By allowing any health practitioner to initiate VAD discussions (provided they present all other options, including palliative care), the modification will ensure comprehensive health information is accessible to all patients. However, consideration should be given to the requirement for health practitioners to complete regulated VAD education training as part of their continuing

[395] Meeting with Gunbalanya School Board and staff, Gunbalanya, 19 August 2025.
[396] Meeting with Aboriginal Engagement and Strategy Unit, Alice Springs Hospital, Alice Springs, 21 August 2025.
[397] Meeting with Pulkapulkka Kari Flexible Aged Care, Tennant Creek, 27 August 2025.
[398] Meeting with Alice Springs Hospital Palliative Care team, Alice Springs, 21 August 2025.
[399] Meeting with Alice Springs Hospital Aboriginal Engagement and Strategy Unit, Alice Springs, 21 August 2025.
[400] Meeting with Pulkapulkka Kari Flexible Aged Care, Tennant Creek, 27 August 2025.
[401] Meeting with Pulkapulkka Kari Flexible Aged Care, Tennant Creek, 27 August 2025.

> professional development before being permitted to introduce the subject of VAD during patient discussions.
>
> It is acknowledged that introducing the subject of VAD does not constitute one of the three proposed VAD assessments, which should remain medically led by appropriately trained and credentialed medical practitioners. (Recommendation 3 in the July 2024 report). This ensures that while initial conversations are broadened for improving accessibility, the core assessments remain under strict medical purview, therefore maintaining appropriate legislative safeguards.[402]

7.18 In the context of Central Australia, the Committee heard that healthcare needs are different and complex. Against this backdrop, the Committee heard that only health practitioners with particular qualifications and training should be able to initiate discussions about VAD and discussions should be guided by a culturally safe clinical practice guide. Alice Springs Hospital Heads of Department stated:

> We believe that clinicians should not be gagged from introducing the topic of VAD with their patients, however neither should there be an expectation that they do so at a particular point in the trajectory of a life-limiting illness. A code of conduct rather than a legislative gag seems most appropriate to support good clinical practice regarding VAD. VAD should always be discussed in conjunction with the options for palliative care, for fully informed awareness of the person's options. Inclusion of topics related to requests for VAD and how to best respond to these should be included in general communication training for medical practitioners in future. Initiation of discussions about VAD with patients should only be done by senior clinicians, or nurse practitioners. Ideally this should be a clinician who has an ongoing relationship with the patient – eg their regular consultant or nurse practitioner or GP. Completion of cultural training should be a pre-requisite for clinicians having discussions about VAD with Aboriginal patients.[403]

7.19 The Committee notes that inclusion of legislative provisions that allow health practitioners/healthcare workers to initiate discussions about VAD and be involved in the VAD process provides protection from liability. Refer to the section 'Protections' in Chapter 12 for further discussion on this topic.

Committee comments

7.20 The Committee considers it appropriate to adopt the same model as many other Australian jurisdictions. This would allow health practitioners and healthcare workers to initiate the discussion of VAD if they also outline other treatment options available, explicitly including palliative care options, and the likely outcomes of the treatments. The Committee acknowledges that this takes a patient-centred approach, enabling the most appropriate practitioner or healthcare worker to initiate the discussion.

7.21 The Committee notes that health workers will need training and clinical guidance on initiating discussions. This will need to occur in the implementation phase. Further, the Committee agrees that discussions about VAD should be culturally safe. In this regard, the Committee considers that healthcare workers should receive appropriate training on culturally safe practices.

7.22 The Committee acknowledges that there may be some circumstances, especially in remote communities or in discussions with Aboriginal people, where initiating a

[402] Submission 369.
[403] Submission 179.

discussion on VAD would not be appropriate or comfortable. In these circumstances, organisations and individuals may choose to have protocols or procedures in place that are specific to their context, noting that healthcare workers are not obligated to initiate discussions about VAD. Refer to Chapter 11 on conscientious objection for further discussion on this topic.

Recommendation 14

The Committee recommends that the legislation should provide that:

a. Medical practitioners are permitted to initiate conversations about VAD with a person in the context of a medical consultation, as long as they also inform the patient about:

i. all treatment options available to the person; and

ii. the nature, scope and availability of palliative care services.

b. Other healthcare workers may initiate conversations about VAD with a person in the context of providing care, as long as they also inform the person that a medical practitioner would be the most appropriate person with whom to discuss the VAD process and other treatment and palliative care options.

c. There should be no restrictions on healthcare workers being able to provide information about VAD to a person who has requested it.

d. Once the topic of VAD has been discussed, there should be no restrictions on further discussions (including in future consultations).

e. In this section, 'healthcare worker' means:

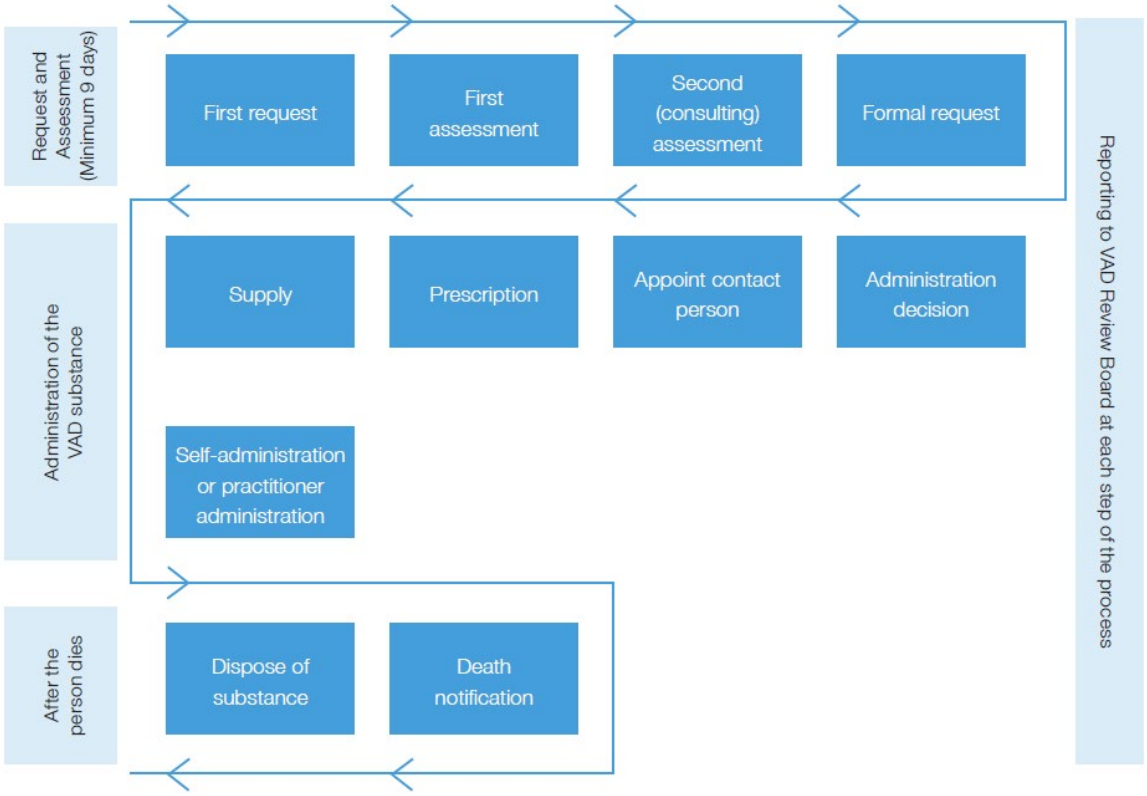
i. a registered health practitioner; or

ii. another person who provides a health service or personal care service.

First request

7.23 The key steps in the request and assessment process recommended by the Committee are set out in Figure 12.

Figure 12: Key steps in the request and assessment process recommended by the Committee



7.24 The VAD process recommended by the 2024 Expert Panel Report requires two requests to be made by a person who want to access VAD. This is to ensure the person's choice is voluntary and enduring. The VAD process commences with a First Request to a medical practitioner to be assessed for VAD.[404] This is followed by a Formal Request after a waiting period.

7.25 The 2024 Expert Panel Report provides limited information and no formal recommendation about the requirements of a First Request. It notes that the first step in the process will involve making a request to be assessed by a VAD Practitioner and that upon making an initial request, patients should be referred immediately to the centralised service.[405]

[404] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 63.
[405] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 63

Approaches in other jurisdictions

7.26 In other Australian jurisdictions, the formal process commences when a person makes a clear and unambiguous First Request for VAD.[406] The request can be made verbally or by communicating in any other way available to the individual, for example through gestures.[407]

7.27 In all states, to be valid, a First Request must be made to a medical practitioner. In the ACT, a First Request can also be made to a nurse practitioner.

7.28 The legislation in each jurisdiction details the steps that practitioners must take upon receiving a First Request. Features of these processes include:

- Circumstances in which the practitioner may or must refuse to accept the First Request, such as that they have a conscientious objection or they are otherwise unwilling or unable to perform the duties of a Coordinating Practitioner;
- Timeframes in which the request should be accepted or refused. This is 2 days in WA, Queensland and NSW except in the case of conscientious objection where refusal should be given immediately. Refer to Chapter 11 for further discussion on conscientious objection;
- Any information that must be provided to the person at the time of the request as provided by the head of the relevant government department;[408] and
- Recording of details of the request in the person's medical record such as the practitioner's decision to accept or refuse the request and confirmation that the person was given the approved information.[409]

7.29 In all jurisdictions, a medical practitioner who accepts a person's First Request becomes the person's Coordinating Practitioner.[410]

Evidence before the Committee

7.30 Submissions and evidence presented to the Committee did not provide specific comment or recommendations on what should be involved in the First Request process.

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[406] *Voluntary Assisted Dying Act 2022* (NSW), s 19(2)(a); *Voluntary Assisted Dying 2021* (Qld), s 14(2)(a); *Voluntary Assisted Dying Act 2021 (SA)*, s 29(2)(a); *Voluntary Assisted Dying Act 2017* (Vic), s 11(2)(a); *Voluntary Assisted Dying Act 2019* (WA), s 18(2)(a). In Tasmania, a patient cannot make a valid first request unless they have received approved information containing the 'relevant facts'. This includes information on the VAD process, the role of the Voluntary Assisted Dying Commission and access to palliative care: *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas), ss 8, 18(2)(a), 18(6).

[407] *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas), s 42(3); *Voluntary Assisted Dying 2021* (Qld), s 14(2); *Voluntary Assisted Dying Act 2021 (SA)*, s 29(2).

[408] See for example, *Voluntary Assisted Dying Act 2019* (WA), s 20(4)(b); *Voluntary Assisted Dying Act 2022* (NSW), s 21(4)(b); *Voluntary Assisted Dying 2021* (Qld), s 164.

[409] See for example, *Voluntary Assisted Dying Act 2017* (Vic), s 14; *Voluntary Assisted Dying Act 2019* (WA), s 21; *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas), s 29; *Voluntary Assisted Dying Act 2022* (NSW), s 22; *Voluntary Assisted Dying 2024* (ACT), s 15.

[410] *Voluntary Assisted Dying Act 2017* (Vic), s 15; *Voluntary Assisted Dying Act 2019* (WA), s 23; *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas), s 22; *Voluntary Assisted Dying Act 2022* (NSW), s 24; *Voluntary Assisted Dying 2024* (ACT), s 14; *Voluntary Assisted Dying Act 2021* (SA), s 33; *Voluntary Assisted Dying 2021* (Qld), s 18.

Committee comments

7.31 The Committee is of the view that the process should generally be consistent with the Australian model of VAD. This is inclusive of a 'clear and unambiguous' First Request made to a medical practitioner, two business days to accept or refuse a request, except where a practitioner conscientiously objects which requires an immediate response, and requirement to provide approved information. This approach requires medical practitioners to ensure that the requestor understands exactly what they are requesting, and ensures the requestor is kept well-informed of the progression of their request and is provided any other information they should have at the First Request stage.

7.32 The Committee is of the view that a model for delivering VAD should not be built into the legislation. The below instructions accommodate a centralised or a community-based delivery model.

Recommendation 15

The Committee recommends that, consistent with the process in other Australian jurisdictions, the legislation should provide that:

a. The formal process to access VAD in the NT should be triggered by a First Request.

b. A First Request must be an explicit request, by the person, for assistance to die.

c. A First Request can only be made to a medical practitioner and must:

i. be made by the person themselves (and not by another person on their behalf); and

ii. be clear and unambiguous (noting that the request may be made verbally or by other means of communication available to the person).

Recommendation 16

The Committee recommends that the legislation should:

a. Allow medical practitioners the choice to accept or refuse the First Request. It should provide that the medical practitioner:

i. May refuse the request if:

- **they have a conscientious objection to VAD; or**
- **they are otherwise unwilling or unable to perform the duties of a Coordinating Practitioner.**

ii. Must refuse the request if they are not eligible to act as a Coordinating Practitioner.

b. Provide that, generally, the medical practitioner should be required to notify the person whether they accept or refuse the First Request within two business days

of receiving the request. However, the medical practitioner should be required to notify the person of their decision immediately if they refuse the request because they conscientiously object to VAD.

c. Provide that, upon receiving a First Request, all medical practitioners should give the patient the *approved information*.

d. Provide that a medical practitioner who receives a First Request must record the details of the request in the person's medical record (including the date of the request, the practitioner's decision to accept or refuse the request, and confirmation that the person was given the *approved information*).

e. Provide that a medical practitioner who accepts a person's First Request becomes the person's Coordinating Practitioner.

Assessments

7.33 The 2024 Expert Panel Report recommended that there should be a requirement for two assessment stages by qualified medical practitioners. During these assessments, the practitioners must:

- consider whether the person meets all of the eligibility requirements for VAD;
- consider whether there is any undue pressure or abuse affecting their decision; and
- provide specified information to the person about diagnosis, treatment options, life expectancy, and the VAD process.

7.34 The 2024 Expert Panel Report proposed the NT legislation would not prescribe how assessors should undertake assessments as it is considered that this is best left to clinical judgement with guidance provided in clinical guidelines.[411]

7.35 The Committee notes the ROTI Act required two medical practitioners to assess and confirm that the person requesting VAD had an eligible illness and was likely to die as a result of the illness.[412] The ROTI Act also required a psychiatrist to assess and confirm that the person requesting VAD was not suffering from treatable clinical depression in respect of the illness.

Approaches in other jurisdictions

7.36 All Australian jurisdictions require the assessment of a person's eligibility for VAD should be undertaken by two independent medical practitioners. [413] The Coordinating and Consulting Practitioner must each assess whether the person meets all the eligibility requirements for VAD.

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[411] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 68.
[412] *Rights of the Terminally Ill Act 1995* (NT), s 7.
[413] See, for example, *Voluntary Assisted Dying Act 2022 (NSW)*, s 25; *Voluntary Assisted Dying Act 2021 (QLD)*, s 19. Refer to the section on 'Qualifications and training' for what is considered an appropriately experienced practitioner.

7.37 In all other jurisdictions, the first assessment is completed by a Coordinating Practitioner and the second assessment by a Consulting Practitioner.[414] These roles have slightly different titles depending on the jurisdiction. The Coordinating Practitioner leads the care of the patient and is required to locate a doctor to provide a consulting assessment.[415] The 2024 Expert Panel Report proposed these roles be adopted in the NT, with the centralised model for VAD allowing the NT to develop a team-based approach to care.

7.38 In Victorian and SA, if there is doubt over the capacity of a person requesting VAD, a Coordinating Practitioner must refer a person to another practitioner with appropriate training, such as a psychologist.[416]

Evidence before the Committee

7.39 In general, stakeholders to the Inquiry supported the approach of other Australian jurisdictions, requiring two eligibility assessments.[417] These stakeholders emphasised the independence of each assessment. The Committee did not receive any specific evidence about the conduct of assessment. However, a small number of stakeholders echoed the 2024 Expert Panel Report's recommendation for the development of clinical guidelines for assessments.[418]

7.40 Consistent with the ROTI Act, some submitters suggested a third assessment should occur with a psychiatrist, psychologist or another mental health professional.[419] However, other submissions pointed to the restrictive nature of requiring a psychiatric assessment, noting instead that such an assessment should only occur if there is clinical doubt about a person's decision-making capacity. The Committee notes this would be consistent with other jurisdictions. The AMA NT stated:

> Mandating a psychiatric assessment for every patient pathologises the VAD process, creates a significant and unnecessary barrier to access, and misuses scarce psychiatric resources. The appropriate and modern safeguard, consistent with good medical practice in all other clinical domains, is for the assessing practitioners—who must be thoroughly trained in capacity assessment—to be required to refer for a specialist psychiatric or geriatric opinion if they have any clinical doubt about the patient's capacity or the presence of a treatable condition that is impairing their judgment.[420]

Committee comments

7.41 The Committee notes the 2024 Expert Panel Report's recommendation for two independent assessments is consistent with other Australian jurisdictions. The Committee considers it appropriate to adopt the same approach.

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[414] End of Life Law Australia, *Voluntary Assisted Dying* (2025), https://end-of-life.qut.edu.au/assisteddying.
[415] *NT Government*, *Voluntary Assisted Dying Independent Expert Panel, Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024 (2024)*, p. 66.
[416] *Voluntary Assisted Dying Act 2018* (Vic), s 18(1).
[417] Submissions 5, 33, 55, 63.
[418] Submission 101.
[419] Submission 112, 147, 336.
[420] Submission 368.

7.42 The legislation should outline the procedural requirements of the assessments, and guidance on how the assessments should be conducted should be provided in clinical guidelines.

7.43 The Committee notes the views of some stakeholders that a psychiatric assessment should occur as a third assessment. However, given the additional barriers this may introduce and the significant resources it would require, the Committee does not consider it appropriate to mandate a psychiatric assessment.

7.44 While the 2024 Expert Panel Report proposed a departure from the Australian model of VAD in relation to referrals for determination, the Committee considered it appropriate for the legislation to mandate a referral for determination in circumstances where the assessing practitioner is unable to determine whether the patient meets specific eligibility requirements.

First Assessment

Recommendation 17

The Committee recommends that the legislation should provide:

a. That the Coordinating Practitioner must assess whether the person is eligible for access to VAD by determining whether they meet each of the eligibility criteria.

b. That, in conducting their assessment, the Coordinating Practitioner should be permitted to consider relevant information prepared by other registered health practitioners.

c. That, if the Coordinating Practitioner is satisfied that the person meets all the eligibility criteria, they must assess them as eligible for access to VAD.

d. That, if the Coordinating Practitioner has determined that the person does not meet one or more of the eligibility criteria, they must assess the person as ineligible for access to VAD.

e. For a process for the Coordinating Practitioner to refer a person assessed as eligible during the First Assessment to a Consulting Practitioner, for a Second Assessment.

Second Assessment

Recommendation 18

The Committee recommends that the legislation should provide that:

a. A medical practitioner who receives a referral from a Coordinating Practitioner to conduct a Second Assessment must accept or refuse the referral. The circumstances in which the practitioner may or must refuse to accept the

referral, and the relevant timeframes, should be identical to those of the First Request.

b. A medical practitioner who accepts the referral becomes the person's Consulting Practitioner.

c. The Consulting Practitioner must independently assess whether the person is eligible for access to VAD by determining whether they meet each of the eligibility criteria.

d. In conducting their assessment, the Consulting Practitioner should be permitted to consider relevant information prepared by other registered health practitioners.

e. If the Consulting Practitioner is satisfied that the person meets all the eligibility criteria, they must assess them as eligible for access to VAD.

f. If the Consulting Practitioner has determined that the person does not meet one or more of the eligibility criteria, they must assess the person as ineligible for access to VAD.

Information to be provided to a person who meets the eligibility criteria

Recommendation 19

The Committee recommends that the legislation should provide that:

a. A person who has been assessed as eligible must be provided with specific information by the Coordinating Practitioner as part of the First Assessment and then again by the Consulting Practitioner as part of the Second Assessment.

b. The Coordinating Practitioner is required to start discussing a plan for administering the VAD substance during the First Assessment.

Referral for determination

Recommendation 20

The Committee recommends that the legislation should provide that:

a. The Coordinating and Consulting Practitioner must refer the person to a registered health practitioner with appropriate skills and training for a determination if they are unable to determine whether the person:

i. has a disease, illness or medical condition that meets the requirements set out in the eligibility criteria; or

ii. has decision-making capacity in relation to VAD.

b. The Coordinating and Consulting Practitioner must refer the person to another person with appropriate skills and training for a determination if they are unable to determine whether the person is acting voluntarily and without coercion.

c. If the Coordinating or Consulting Practitioner makes a referral under paragraphs a or b, they may (but are not required to) adopt the determination.

d. A registered health practitioner or other person to whom a referral is made under paragraphs a or b must not be a Family Member of the person requesting VAD or stand to benefit from the person's death (financially or in another material way).

Formal Request

7.45 Multiple requests act as coercion prevention measures and the formality of a signature is another safeguard to ensure the request is voluntary, enduring and comes from the person themself. The 2024 Expert Panel Report recommended that the NT process consist of two requests: a First Request and a (second) Formal Request.[421] Following the assessment process, a person who has been assessed as eligible for VAD may make a Formal Request for VAD.

7.46 Consistent with the Australian model of VAD, the request must be signed by the person and witnessed by two witnesses. The 2024 Expert Panel considered that excluding family members or culturally significant decision-makers, as occurs in other Australian jurisdictions, from being a witness is too restrictive. It proposed that one of the witnesses may be a beneficiary under the person's will.

7.47 To ensure that the person's request is enduring, there should be a minimum designated timeframe between the (accepted) First Request and the Formal Request. Consistent with the Australian model of VAD, this timeframe may be shortened in cases where the person may die or lose decision-making capacity. The 2024 Expert Panel Report did not recommend a specific timeframe.

7.48 The Expert Panel considered that, where an interpreter is involved in the Formal Request, they should certify that they provided a true and correct translation of relevant materials. To comply with this certification, the interpreter must also be qualified or credentialled as a translator in the required language.

7.49 The Committee notes the 2024 Expert Panel Report did not consider whether, following the Formal Request, the Coordinating Practitioner should undertake a Final Review, as is generally required in the Australian model of VAD.[422]

Approaches in other jurisdictions

7.50 Unlike the 2024 Expert Panel Report's recommendations, all other jurisdictions require three requests to access VAD. One request must be in writing with two witnesses present for the written request, with flexibility built in for people who cannot sign a written request themselves.[423]

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[421] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), Recommendation 15, pp. 69 and 98.
[422] K. Waller et al., 'Voluntary Assisted Dying in Australia: A Comparative and Critical Analysis of State Laws', *University of New South Wales Law Journal* 46(4) (2023).
[423] See for example, *Voluntary Assisted Dying Act 2019* (WA), Divisions 2, 5 and 6; *Voluntary Assisted Dying Act 2021* (SA), Division 3; *Voluntary Assisted Dying Act 2021* (QLD), Divisions 1, 4 and 5.

7.51 In all other States, VAD legislation requires that a Formal Request cannot be made until the end of a determined timeframe after the first request to ensure the person's request is enduring and not coerced.[424] For example, the legislation in Victoria and WA ordinarily requires a period of at least nine days between a person's first and final requests and NSW requires five days.[425] In cases where the person may die or lose capacity if required to await the determined timeframe, the Coordinating Practitioner and Consulting Practitioner can authorise an earlier request.[426]

Evidence before the Committee

7.52 In general, the Committee found support for the requirement to have at least one request being made formally in writing. However, the Committee observed some need for flexibility in this requirement to account for people who cannot physically write. In their submission, Christians Supporting Choice for Voluntary Assisted Dying suggested that a Formal Request should be made in writing. However, they noted that there should be access designed to help those who cannot physically write a request.[427]

7.53 In a remote community, the Committee heard from disability advocates about the need for supports for people with disabilities who communicate in different ways. Advocates emphasised there should be "enough checks and balances in the system" to allow a person to use communication aids, whilst ensuring they are not subject to coercion.[428]

7.54 In remote communities, the Committee heard there would need to be assistance with how a Formal Request is made. In several communities, individuals suggested that any Formal Request or consent form should be translated to ensure the person fully understands their request.[429] An interpreter stated:

> The written thing is the cultural part when people make decisions… The consent should be verbal. A lot of people here cannot speak English and I am only one interpreter. I would prefer verbal consent and, as an interpreter, it would be there.[430]

7.55 A community member suggested that consent could be given in alternative way via video. They requested "make it both ways so that they can understand too, by seeing it not just by saying it".[431]

7.56 Submitters had varied opinions on the timeframes between the first request and Formal Request ('cooling off period'). Some submitters stakeholders suggested no period should be prescribed.[432] Others, gave preference to the NSW approach of five

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[424] See, for example *Voluntary Assisted Dying Act 2017* (Vic), s 38; Voluntary Assisted Dying Act 2019 (WA), s 48; *Voluntary Assisted Dying Act 2021* (SA), s 56.
[425] *Voluntary Assisted Dying Act 2017* (Vic), s 38(1)(a); *Voluntary Assisted Dying Act 2019* (WA), ss 48(1), (2)(a). [add NSW]
[426] See, for example, *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas), s 30(2).
[427] Submission 71.
[428] Community drop-in session, Tennant Creek, 27 August 2025.
[429] For example, meeting with St Matthew's Anglican Church, Ngukurr, 6 August 2025.
[430] Meeting with St Matthew's Anglican Church, Ngukurr, 6 August 2025.
[431] Meeting with St Matthew's Anglican Church, Ngukurr, 6 August 2025.
[432] See for example, Submissions 35, 41, 71, 83.

days.[433] Some stakeholders suggested nine days was appropriate.[434] A small number of submitters suggested the period should be longer than other jurisdictions.[435]

Committee comments

7.57 The Committee recognises the necessity of a Formal Request, noting the importance of ensuring the request is voluntary, enduring and comes from the person themselves. The Committee received limited evidence on this issue. Accordingly, the Committee considers that the 2024 Expert Panel Report's Recommendation 15 was appropriate.

7.58 The Committee considers that the designated timeframe between requests should be broadly consistent with the Australian model for VAD noting that most states require a minimum of nine days between the First and Formal Request, whilst NSW imposes a minimum of five days. Noting the diversity of views in the evidence, the Committee considers that nine days is suitable. The legislation should permit this requirement to be waived in circumstances where both the Coordinating and Consulting Practitioner agree that the person is likely to die or lose decision-making capacity before the end of the designated timeframe.

7.59 Consistent with the Australian model of VAD, the Formal Request must generally be signed by the person and witnessed by two witnesses. However, the Committee recognises the importance of ensuring that the Formal Request is accessible to all individuals who would like to request VAD. In this regard, the Committee considers that there must be adequate flexibility to accommodate people who cannot physically write and those who, for cultural reasons, need to make the request via an alternative mode, including via video. Accordingly, the Committee considers it appropriate for the legislation to set out video recording as an alternative way of communicating and documenting the request.

7.60 Where an interpreter is involved in the Formal Request, they should certify that they provided a true and correct translation of relevant materials. To comply with this certification, the interpreter must also be qualified or credentialled as a translator in the required language.

7.61 In line with the 2024 Expert Panel Report, the Committee finds that excluding family members or culturally significant decision-makers, as occurs in other Australian jurisdictions, from being a witness is too restrictive. It proposed that one of the witnesses may be a beneficiary under the person's will.

Form of Formal Request

Recommendation 21

The Committee recommends that the legislation should provide that:

a. A person who has been assessed as eligible for VAD by the Coordinating and Consulting Practitioner may make a Formal Request for VAD.

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[433] See for example, Submission 157.
[434] See for example, Submission 108.
[435] Submission 67.

b. The Formal Request must be in an approved form and signed by the patient in the presence of two eligible witnesses.

c. The person must certify that they are making the request voluntarily and understand the purpose of the Formal Request.

d. The person is required to give the completed Formal Request to the Coordinating Practitioner.

Patient signature

Recommendation 22

The Committee recommends that the legislation should provide that, if the patient is unable to sign the Formal Request, another adult can sign the Request in the presence of, and at the direction of the person. This other person cannot be the Coordinating or Consulting Practitioner, or one of the two witnesses.

Eligible witnesses

Recommendation 23

The Committee recommends that the legislation should:

a. Prescribe eligibility requirements to act as a witness. Witnesses should be at least 18 years old, and only one witness may be a Family Member of the person accessing VAD, or a beneficiary under the person's will.

b. Provide that the person's Coordinating and Consulting Practitioner, and anyone who is the owner or manager of a health and/or care entity where the person is being treated, or resides, should not be permitted to witness the Formal Request.

c. Provide that witnesses should be required to certify in writing that they witnessed the person signing the Formal Request, and that the person appeared to be acting freely and voluntarily.

Alternative form of Formal Request

Recommendation 24

The Committee recommends that the legislation should:

a. Provide that, despite the requirements in Recommendation 23, and to acknowledge cultural preferences and promote cultural safety, the legislation may set out an alternative process for making a Formal Request, via a video recording.

b. Provide that, a Formal Request made by video recording would need to comply with a number of formalities, including (but not limited to):

i. the Coordinating Practitioner being present to witness the recording;
ii. the person clearly identifying themselves (by providing their name and date of birth);
iii. the person declaring that:

- **they are making a Formal Request for VAD in the presence of two witnesses and the Coordinating Practitioner;**
- **they are making their request voluntarily and free from coercion; and**
- **they understand the nature and effect of their request; and**

iv. interpreter certification, where relevant as per Recommendation 27a and 27b.

c. Detail witnessing requirements for Formal Requests made by video recording.

d. Provide that the Coordinating Practitioner should be required to submit the video recording and written documentation detailing the Formal Request to the Review Board, within two business days of the Formal Request.

Use of interpreters

Recommendation 25

The Committee recommends that the legislation should provide that:

a. In circumstances where the Formal Request is made with the assistance of an interpreter, the interpreter should be required to certify that they provided a true and correct translation of relevant materials.

b. To comply with certification requirements, the interpreter must also be a qualified translator.

Designated timeframe

Recommendation 26

The Committee recommends that the legislation should:

a. Designate a minimum timeframe of nine days between the (accepted) First Request and the Formal Request.

b. Permit this requirement to be waived in circumstances where both the Coordinating and Consulting Practitioner agree that the person is likely to die or lose decision-making capacity before the end of the designated timeframe.

Use of Interpreters

7.62 In Australia there are significant challenges to VAD access complicated by low health and legal literacy. These challenges are compounded by a lack of English language literacy.[436] In this regard, the availability of suitable interpreters is critical to enabling people to fully understand and access VAD.

[436] B. P. White, R. Jeanneret and L. Willmott, 'Barriers to Connecting with the Voluntary Assisted Dying System in Victoria, Australia: A Qualitative Mixed Method Study', *Health Expectations* 1(14) (2023).

7.63 There is significant language diversity in the NT, with over 200 languages spoken.[437] In this context, the ROTI Act required the use of interpreters for signing request certificates to certify that the person requesting VAD fully understood their decision.[438] The ROTI Regulations set out the specific professional qualifications the interpreter was required to hold.[439]

7.64 The 2024 Expert Panel Report recommended that interpreters providing interpretation services in relation to VAD must be accredited and meet other requirements specified by the Review Board. It also recommended that the involvement of interpreters should be documented and reported to the Review Board at each stage of the VAD process.[440]

7.65 The Committee notes that there may be some specific challenges associated with interpreters for Aboriginal Territorians, including:

- the cultural sensitivity associated with the subject matter of death and dying;
- risks associated with blame and payback; and
- kinship ties that may exist between an interpreter and a person seeking VAD, which may involve cultural obligations.

7.66 Throughout the VAD process, patients should have ready access to qualified and culturally appropriate interpreters. Recognising that access to suitable interpreters can be challenging in small Aboriginal communities, the 2024 Expert Panel Report suggested that the development of appropriate interpreter safeguards and protocols could occur under the supervision of the Review Board.

Approaches in other jurisdictions

7.67 Presently, all Australian jurisdictions have conditions for when an interpreter is required and how this is recorded.[441] In summary, the medical practitioner conducting the initial VAD assessment must determine whether an interpreter is required and record this information on the assessment form they submit to the Review Board. The interpreter must certify that the VAD request was made by a person who has the capacity to understand their decision. The NT could also follow this model.

7.68 In other Australian jurisdictions, interpreters must be accredited by the National Accreditation Authority for Translators and Interpreters (NAATI). The Review Boards may also specify other training and accreditations that must be undertaken. Some

[437] NT Health, *Strategic Plan 2023-2028* (2023), p. 6.
[438] *Rights of the Terminally Ill Act 1995* (NT), s 7(1)(l).
[439] Rights of the Terminally Ill Regulations 1997 (NT), regulation 6.
[440] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), Recommendation 5.
[441] See for example, *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas), ss 15(2)–(4).

jurisdictions provide specific guidance to interpreters working in VAD.[442] Some of these requirements are specified in their respective VAD Regulations.[443]

Evidence before the Committee

7.69 Many stakeholders emphasised the importance of appropriately qualified interpreters in a VAD process. This included Aboriginal interpreters,[444] foreign language interpreters,[445] and Australian Sign Language (Auslan) interpreters.[446] Some stakeholders also emphasised the need for broader communication supports, such as speech pathologists, to ensure all individuals can fully understand and communicate their choices.[447]

7.70 Some submitters noted that interpreters should not be required during the VAD process.[448] Some stakeholders expressed concern that interpreters could inadvertently influence a patient's decision or raise risks of coercion.[449] There were also fears that community members might perceive interpreters as having ulterior motives or even engaging in harmful practices such as "cursing" or black magic.[450] The Committee notes this could discourage both patients and interpreters from participating in the VAD process.

7.71 Poor communication between health professionals and patients was identified in evidence to the inquiry as a major issue that can affect healthcare outcomes. Misunderstandings can lead to mistrust, readmissions, and patients leaving care prematurely.[451] Dr Penny Stewart, Head of Department, Alice Springs Hospital, stated:

> …our Aboriginal workforce is key and actually ensuring their safety, ensuring better doctors better communication and listening to their voices is absolutely key to everything that we do. Because if you look at all of the problems around the hospital; like readmissions, take your own leave, lack of trust, it is all because of miscommunication and no relationship.[452]

7.72 In some cases, family members serve as informal interpreters, which in some cases may be inadequate for navigating complex medical information.[453] Witnesses

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[442] See for example, NSW Government, NSW Health, *Voluntary assisted dying in NSW – Information for interpreters* (2023), https://www.health.nsw.gov.au/voluntary-assisted-dying/Factsheets/information-for-interpreters.pdf.
[443] See for example, *Voluntary Assisted Dying Act 2017* (Vic), s 115; Voluntary Assisted Dying Regulations 2018 (Vic), regulation 11.
[444] Submissions 51, 63, 71, 95; Meeting with the Aboriginal Engagement and Strategy Unit, Alice Springs Hospital, Alice Springs, 21 August 2025. Aboriginal Medical Services Alliance NT, Public Hearing, Darwin, 5 August 2025.
[445] Submission 51; Australian Medical Association NT, Public Hearing, Darwin, 5 August 2025.
[446] Submission 51.
[447] Submission 182.
[448] Submission 149.
[449] Submission 149.
[450] Meeting with Alice Springs Hospital Aboriginal Engagement and Strategy Unit, Alice Springs, 21 August 2025.
[451] Meeting with Alice Springs Hospital Aboriginal Engagement and Strategy Unit, Alice Springs, 21 August 2025.
[452] Meeting with Alice Springs Hospital Aboriginal Engagement and Strategy Unit, Alice Springs, 21 August 2025.
[453] Meeting with community representatives of Maningrida, Darwin, 25 August 2025.

emphasised the need for better integration of Aboriginal health workers and interpreters to support communication and ensure that care instructions are clearly understood and culturally appropriate.[454]

7.73 The Committee heard that discussing death and dying is highly sensitive in many Aboriginal communities, with certain words or concepts avoided entirely. This creates significant challenges for accurately explaining VAD, as key terms may not directly translate into Aboriginal languages.[455] In a remote community, the Committee heard these concerns from aged care nursing staff:

> They will not [talk about VAD]. They do not talk about it… but even the interpreters they interpret how they want… [T]here are certain words in their language that they do not talk about. They do not use those certain words.[456]

7.74 Similarly, Dr John Zorbas, President of the AMA NT, stated:

> There is a huge importance on the use and the appropriate resourcing of interpreters. A lot of healthcare is done in language and a lot of it is not done in language. This is a space you have to be 100% certain that the decisions that are being made are being understood and the capacity is an essential component of this. Where interpreters are required, people must have access to those interpreters who must be appropriately trained. There are some concepts in VAD that do not have terminology in other languages, not just speaking to Indigenous culture but also other cultures that we have in the NT. Those interpreters will need to have formal training in that space as well.[457]

7.75 Some interpreters stated they would not participate in VAD discussions due to cultural laws and fear of serious repercussions.[458] These factors limit the pool of interpreters available to support patients in end-of-life care. When asked whether they would be comfortable speaking about VAD to a client, an ALO and interpreter stated:

> No I wouldn't. It is against their law… We'd get speared, it's not my place, anyway it is the families they have got to talk about it and they don't do that.[459]

7.76 Many communities reported a shortage of qualified interpreters, leaving patients without the support needed to understand medical information or participate in decisions about their care.[460] Witnesses identified poor pay and insecure working conditions as key contributors to this shortage. Interpreters are often paid only for the minutes they spend interpreting, without compensation for travel costs, making the role financially unsustainable and leading to high workforce turnover.[461] Patrick Torres, Aboriginal Cultural Coordinator, Alice Springs Hospital, stated:

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[454] Meeting with Alice Springs Hospital Aboriginal Engagement and Strategy Unit, Alice Springs, 21 August 2025.
[455] Submission 182; Meeting with Pulkapulkka Kari Flexible Aged Care, Tennant Creek, 27 August 2025.
[456] Meeting with remote community representatives August 2025.
[457] Australian Medical Association NT, Public Hearing, Darwin, 5 August 2025.
[458] Meeting with an Aboriginal Liaison Officer, August 2025.
[459] Meeting with Alice Springs Hospital Aboriginal Engagement and Strategy Unit, Alice Springs, 21 August 2025.
[460] Meeting with community representatives, Barunga, 12 August 2025.
[461] Meeting with Alice Springs Hospital Aboriginal Engagement and Strategy Unit, Alice Springs, 21 August 2025.

> A lot of our interpreters, fortunately with our staff they are getting a permanent wage but when you look at the interpreters they actually get paid for the job, for the exact work they do. So if we get an interpreter from the AIS [Aboriginal Interpreter Service] to come to the hospital; so they may travel from out at Larapinta pay their own taxi fare into town go up and do a 15 to 30 minutes job and only get paid for that… they don't get reimbursed for the taxi fares, so why would you work in that field. I mean if you look at the other side of it, and then hence why we lost a lot of the interpreters in the AIS.[462]

Committee comments

7.77 Language should not be a barrier to accessing VAD. In this regard, a person should have the right to request an objective interpreter to help them to communicate their end-of-life choices.

7.78 Consistent with Recommendation 5 of the 2024 Expert Panel Report and approaches in other jurisdictions, the Committee considers that interpreters should be available at all stages of the VAD process. These interpreters should be appropriately trained and accredited to interpret highly sensitive subject matter. The Committee notes that other Australian jurisdictions require interpreters to be NAATI accredited and the Review Boards may also specify other training and accreditations. The Committee considers this to be an appropriate approach. The Committee also considers it is important to ensure that interpreters are recorded and certify their involvement at each step to the Review Board.

7.79 The Committee notes concerns about the impartiality of interpreters and the possibility of this resulting in coercion to choose VAD. In this regard, the Committee understands that it may not be appropriate for interpreters to be family members, someone who may financially benefit from the person's death, or those involved in the person's care.

7.80 However, the Committee notes that Aboriginal Territorians may face additional barriers in accessing appropriate interpreters. Evidence presented to the Committee indicates there are shortages of Aboriginal interpreters in particular languages and communities. There is also a possibility that many interpreters will not be willing to take part in VAD. In this regard, the Committee notes that certain exemptions may need to apply to enable Aboriginal Territorians to have the ability to understand and communicate their decisions about VAD. The Committee considers that the appropriateness of these exemptions will need to be assessed on a case-by-case basis and would most appropriately sit as a function of the Review Board.

Recommendation 27

The Committee recommends that the legislation should:

a. Set out the requirements of interpreters providing services for persons accessing VAD.

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[462] Meeting with Alice Springs Hospital Aboriginal Engagement and Strategy Unit, Alice Springs, 21 August 2025.

b. Provide that interpreters must be accredited by a body approved by the Review Board.

c. Provide that interpreters must not:

i. be a Family Member of the person;

ii. know or believe that they will benefit financially from the person's death (including as a beneficiary under the person's will);

iii. be directly involved in the person's care; or

iv. be the owner or manager of a health or residential facility where the person is being treated or resides.

d. Provide that, despite the above, the Review Board may authorise an interpreter who does not meet the requirements to provide interpretation services if it is satisfied that:

i. no other suitable interpreter is available; and

ii. there are exceptional circumstances that justify the authorisation.

e. Provide that, at each step of the process where an interpreter is involved, Authorised VAD Practitioners are required to document and report their involvement to the Review Board. Information should include the name, contact details and accreditation details of the interpreter. Interpreters should also certify their involvement at each step.

Transfer of Coordinating Practitioner role

7.81 To support a person's access to VAD, a Coordinating Practitioner should be able to transfer their role at the request of the patient, or if they become unavailable.

Committee comments

7.82 The Committee did not receive any evidence in relation to this matter and the 2024 Expert Panel Report does not make a recommendation about the procedure for transferring the Coordinating Practitioner's role.

7.83 The Committee's recommended approach is consistent with most other Australian jurisdictions.

Recommendation 28

The Committee recommends that the legislation should:

a. Allow the Coordinating Practitioner's role to be transferred at the request of the patient, or because the Coordinating Practitioner is no longer available to perform the duties of the Coordinating Practitioner.

b. Provide that the role of Coordinating Practitioner may be transferred to the Consulting Practitioner, subject to the Consulting Practitioner:

i. having assessed the person as eligible for VAD during a Second Assessment; and

ii. **accepting the transfer.**

c. **Provide that the Consulting Practitioner must inform the Coordinating Practitioner whether they accept or refuse the transfer within two business days.**

d. **Provide that, if the Consulting Practitioner accepts the transfer, the original Coordinating Practitioner must inform the patient of the transfer and submit the necessary form to the Review Board.**

e. **Provide that, if the Consulting Practitioner refuses the transfer, the Coordinating Practitioner may refer the person to another medical practitioner for a further Second Assessment and then follow the transfer process outlined above.**

f. **Provide for a simple mechanism by which the original Coordinating Practitioner can resume their role at the request of the patient.**

Use of telehealth

7.84 Telehealth is successfully used in the NT for the delivery of healthcare where there is adequate IT infrastructure, medical practitioners and patients are knowledgeable in operating it and interpreters are readily available where needed.

7.85 Under current Commonwealth legislation however there are restrictions on its use in the delivery of VAD. The *Criminal Code Act 1995* (Cth) criminalises the use of telecommunications (including telephone, fax, email, use of audio-visual communication or via the internet) to disseminate 'suicide-related materials'.[463] Accordingly, telehealth is used for limited functions under VAD schemes in most Australian jurisdictions.[464]

7.86 The pressing need for reforms to this Commonwealth legislation was clearly articulated in many submissions to this inquiry, including from the Australian Lawyers Alliance,[465] AMA NT,[466] Urapuntja Health Service Aboriginal Corporation,[467] Dying with Dignity Tasmania,[468] Dying with Dignity NSW,[469] and the Royal Australian and New Zealand College of Psychiatrists.[470]

7.87 The Committee concurs with the 2024 Expert Panel recommendation that the NT VAD legislation should not prohibit the use of telehealth for the purpose of conducting VAD consultations, however, at least one of the eligibility assessments should be conducted in person.[471]

7.88 The use of telehealth has been a key issue in VAD Review Board annual reports across Australia. Broadly, other jurisdictions have noted that the Commonwealth prohibition negates accessibility to VAD for residents in regional and remote areas. It was also

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[463] *Criminal Code Act 1995* (Cth), s 474.29A2.
[464] *Carr v Attorney-General (Cth)* [2023] FCA 1500.
[465] Submission 157.
[466] Submission 368.
[467] Submission 22.
[468] Submission 163.
[469] Submission 321.
[470] Submission 159.
[471] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), Recommendation 13.

noted that the prohibition on telehealth may inhibit a person's ability to access a suitable interpreter.[472]

Approaches in other jurisdictions

7.89 Most Australian jurisdictions allow the use of telehealth for the delivery of some components of their VAD service.

7.90 For example in Tasmania, as explained in the *VAD Clinical Practice Handbook*, informing people about the laws and associated processes (either in general terms, or in relation to a person's specific circumstances) may be undertaken by a carriage service to the extent that the information does not counsel, encourage or incite the choice of VAD or promote a particular method or provide instruction about taking or administering a VAD Substance. Eligibility determinations up to and including the Formal Request may also be conducted via a carriage service if clinically appropriate. All other steps in the VAD process should occur in person, including the Final Permission.[473]

7.91 In Queensland, discussions and activities that can be undertaken via a carriage service to the extent that the information does not advocate, encourage, incite, promote, urge or teach about how to undertake the act of administration of a VAD Substance include:

- Responding to questions and informing people about the VAD legislation and associated processes in Queensland (either generally or in relation to a person's circumstance);
- A First Request;
- A first or consulting assessment;
- Submitting approved forms for any step in the process to the Review Board via Queensland VAD (QVAD) Review Board Information Management System (IMS); and
- General communication about VAD with the QVAD-Support, QVAD-Pharmacy, interpreters, or other healthcare workers.[474]

Evidence before the Committee

7.92 Telehealth is commonly used in the NT. It is a valuable method of communication and mode of healthcare delivery given the remoteness of the territory, high cost of travel, inability to travel in some seasons, shortage of medical staff including specialists, doctors and nurses and the frailty/poor health of many patients.

7.93 As the Acting CHO, NT Health, Dr Paul Burgess explained to the Committee when asked about whether telehealth forms a large part of the NT healthcare system:

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[472] Western Australian Government, Voluntary Assisted Dying Act Review Panel, *Statutory Review – Voluntary Assisted Dying Act 2019 - Final Report 2024* (2024), p. 5.
[473] Tasmanian Government, Department of Health, *Voluntary Assisted Dying: Clinical Practice Handbook* (2024), p. 31
[474] Queensland Government, *Queensland Voluntary Assisted Dying Handbook*, Version 2.0 (2022), p. 44

> It depends who you ask. There is certainly some craft groups have been strongly adopting telehealth. GPs who only spend short amount of times in remote communities often use telehealth. A lot of specialty colleagues, particularly in psychiatry, have been our strongest proponents of telehealth. There are some medical specialties for which they need to put their hands on the patient, and telehealth is not as appropriate.[475]

7.94 In remote communities, the Committee heard mixed responses to the utility of telehealth. Positive experiences of telehealth were shared with the Committee at its consultation in Gunbalanya.[476] The Executive Health Manager from Mala'la Health Services (Maningrida) noted that:

> We have a telehealth service at aged care and we are in the process of purchasing another telehealth card—a new one for the clinic. We already have one.
>
> We also employ three telehealth doctors. They work offsite. One works from Queensland; one works from Victoria; and one works from Darwin. Two of those are available each day. One of them has been with the organisation for seven years, both onsite and offsite. A lot of people have a very good relationship with her. That makes a difference. She is responsible for aged care, and she will often pick up some palliative care as well.
>
> Then we have an onsite doctor who is permanent. She has been there for seven years. She has a great relationship with the community and also deals with a lot of the telehealth. We have locums. We normally have three doctors on the ground all the time, plus three telehealth doctors. We have extremely good medical services and they all have a fairly long relationship with the organisation at Maningrida. Most of our locums are returning locums. We do not get many new locums. We have a relationship where we just plan for the year ahead. That provides a lot more services as well.
>
> I do not think our telehealth services are perfect, but they are certainly improving with the additional telehealth doctors. At any time a nurse can go out to a person's house and dial the telehealth doctor and have them there to talk to them, FaceTime them or whatever. I think that helps.[477]

7.95 In contrast, telehealth is not an option where there is poor Information Technology (IT) infrastructure, low IT literacy and some elderly patients have difficulties communicating. In Barunga at the community drop-in session, the Committee was advised via the interpreter:

> Sometimes when family is ready for finish. When the doctor mob from Darwin or Katherine want to talk to the family here. Do they do video link up…? They talk through the video?…
>
> Nothing. There are no resources or no-one to facilitate for it to happen…
>
> I do not think it is very—we have the courts here. We cannot do video links… it cuts out… and we just talk through the phone if they are in another place. We just do the phone, on the mobile phone-no video links.[478]

[475] NT Health, Public Hearing, Darwin, 5 August 2025.
[476] Meeting with Gunbalanya School Board and staff, Gunbalanya, 19 August 2025.
[477] Meeting with community representatives of Maningrida, Darwin, 25 August 2025.
[478] Meeting with community representatives, Barunga, 12 August 2025.

7.96 Similarly, when asked about whether there was a video telehealth service, community members in Papunya (Figure 13) reported that doctor consults occur "sometimes on television and sometimes just by phone" but there is rarely an interpreter assisting.[479]

Figure 13: Community consultation in Papunya on 20 August 2025

7.97 Many people who made submissions and gave evidence to this inquiry are supportive of a role for telehealth in the delivery of VAD in the NT.[480] Dr John Zorbas, President of the AMA NT, explained how useful it could be in delivering VAD with appropriate safeguards and ensuring equity of access:

> Other jurisdictions have a minimum of two consultations by a suitably qualified medical professional to decide around VAD eligibility and access to VAD. Ideally, if one of those was to be done over telehealth, that would help equity of access. If telehealth was not available, that would commit us to having to do two face-to-face in-person consultations. With that comes the cost of transport, given the fly-in fly-out nature of what is likely to be a centralised VAD service in the Northern Territory. There is a cost associated with that. That will lead to delays. When we

[479] Meeting with community representatives, Papunya, 20 August 2025.
[480] For example, refer to Submissions 3, 4, 21, 34, 51, 66, 71, 72, 125, 147, 159, 161.

> are talking about issues like access to voluntary assisted dying prior to death from a terminal condition, those delays will push some people past the ability to use VAD and to access VAD. Whilst it might not lead to an unsafe service, it will lead to a less effective and a less quality-focused service.
>
> ...
>
> Maybe I can answer it by saying what has changed in the past 12 months. Telehealth would have to be the biggest one. Post-COVID the expectation of telehealth as part of medical care, even amongst the general population let alone doctors, is hugely important of our abilities to deliver care. The prohibition on using telehealth to provide access to healthcare in this setting—this unique problem we are faced with, VAD—ideally should be addressed. I appreciate that is a federal question and not necessarily something that we have complete control over, from a Territory point of view. It is something we would need to agitate for and address as part of any VAD service. The use of telehealth will significantly affect our outreach capacity and the resourcing requirements. It is not necessarily the game changer in making the service viable or not from a financial standpoint, but it certainly means that we can do more with less.

7.98 The Committee received very few submissions that object to the use of telehealth. These submissions were mainly against the delivery of a VAD service in the NT altogether.[481]

Committee comments

7.99 The Committee highlights the importance of equity of access to VAD. The Committee agrees with the 2024 Expert Panel Report, and notes that, while in-person consultations in the context of healthcare are generally preferred, the use of telehealth can facilitate access to VAD for Territorians living in rural and remote areas, or those unable to travel due to their medical condition. The Committee notes the 2024 Expert Panel Report's observation that the ability to use telehealth would reduce financial and time costs of seeking VAD.

7.100 Despite the benefits of telehealth, the 2024 Expert Panel Report reported on the restrictions imposed by the *Criminal Code Act 1995* (Cth) in relation to the use of telehealth in the context of VAD. Whilst noting this restriction, the Committee also observes that other jurisdictions use telehealth for some components of their VAD service delivery. The Committee considers that the NT legislation should remain open to future amendments to Commonwealth legislation.

Recommendation 29

The Committee recommends that the legislation should provide that:

a. If it is not practicable for a patient to attend a VAD consultation in person, the consultation may occur via telehealth, subject to the requirement that one of the eligibility assessments be conducted in person.

b. Despite the above, telehealth is not authorised if, or to the extent that, its use would breach the *Criminal Code 1995 (Cth)*.

[481] For example, refer to Submissions 84, 154, 174, 334.

8 Administration of the VAD Substance

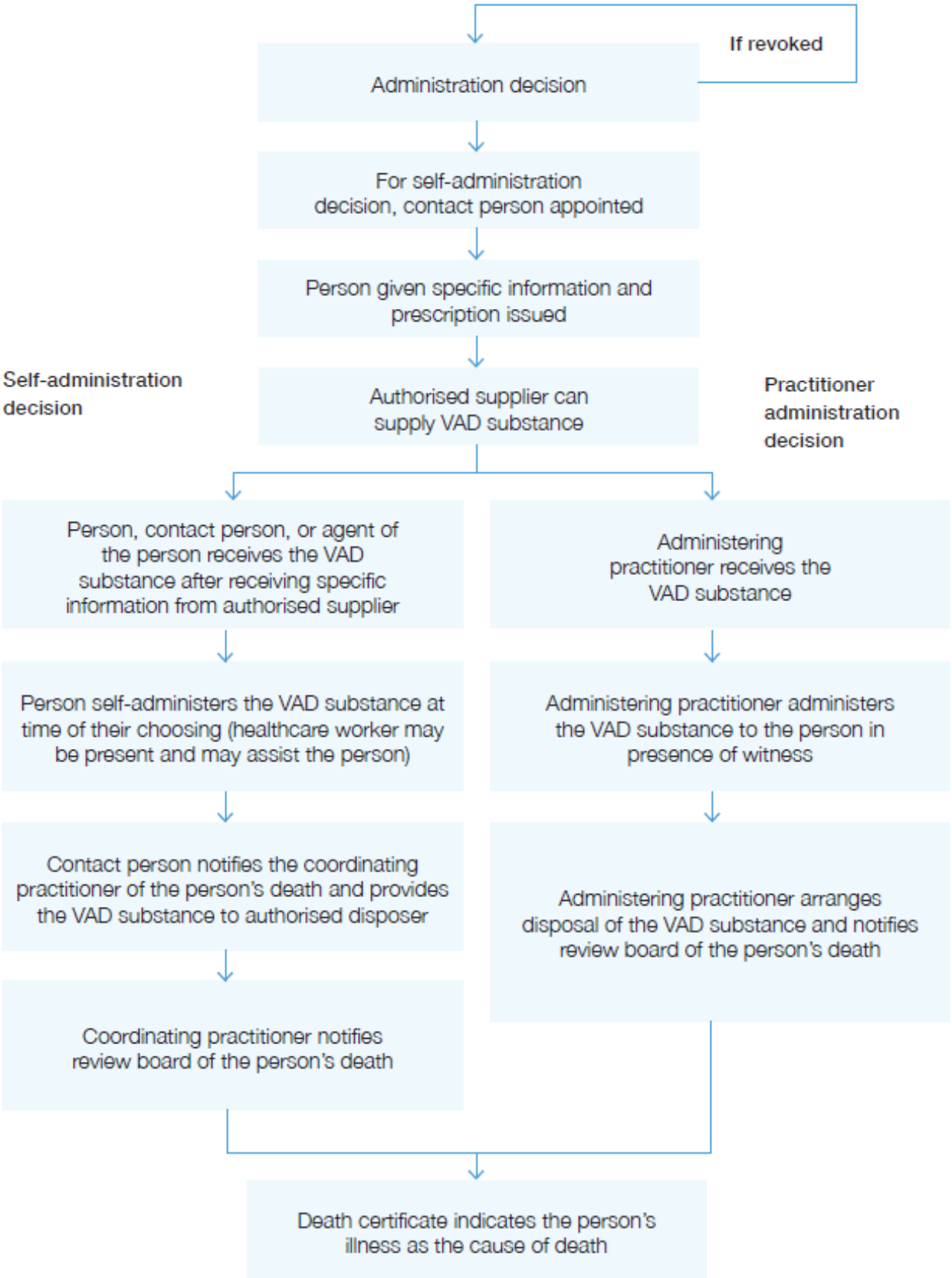
Overview

8.1 VAD legislation across Australia sets out the process to have the VAD Substance administered once a person has been deemed eligible through the request and assessment process.

8.2 This Chapter examines these processes including: the process to choose between Self-Administration or Practitioner Administration; the role of a Contact Person; whether a permit to access VAD is required; the rules for the supply, storage and disposal of the VAD Substance; requirements for a witness at the time of Administration; and how to transfer the role of Administering Practitioner if required.

8.3 The Committee's recommended process is illustrated in Figure 14.

Figure 14: Administration process



Administration Decision

8.4 If assessed as being eligible for VAD, a person may decide how the VAD Substance is administered, in consultation with their Consulting Practitioner. This is called an Administration Decision. A person may choose between Practitioner Administration or Self-Administration. In general, Self-Administration is performed by ingesting a liquid at the time and place of the person's choosing. Practitioner Administration is via intravenous injection by an Administering Practitioner.

8.5 There are a number of issues that must considered in making an Administration Decision. The Committee notes that giving choice as to method of administration is an important way to give patients more autonomy about the manner and timing of their death.[482]

8.6 Although not covered in a formal recommendation, the 2024 Expert Panel Report supported a person's right to choose between Self-Administration and Practitioner Administration.[483] The Committee notes that consideration of administration options will also need to have regard to ensuring the safe supply, storage and disposal of the VAD Substance where Self-Administration is selected.

Approaches in other jurisdictions

8.7 In other Australian jurisdictions, a person's Administration Decision must be clear and unambiguous, and the person may communicate an Administration Decision by gesture or other means.

8.8 In Victoria, SA, WA and Queensland Self-Administration is the default setting only allowing Practitioner Administration if Self-Administration is inappropriate or not possible.[484] NSW and the ACT allow a person to choose Practitioner or Self-Administration.[485] Annual reports from WA and NSW suggest that there is a clear preference for people to have health practitioner-assisted VAD.[486] In Tasmania, there are several options for administration, including the option for supervised Self-Administration. This is when a person self-administers the VAD Substance whilst the Administering Practitioner is in close proximity to the person.[487]

8.9 The legislation in some Australian jurisdictions includes factors which are relevant to (but do not necessarily dictate) a person's choice of administration method, including the person's physical ability to self-administer the VAD substance, the person's concerns about administration and the method of administration suitable for the

[482] B. White and L. Willmott, 'A Model Voluntary Assisted Dying Bill' (2019), *Griffith Journal of Law & Human Dignity* 7(2), p. 7.
[483] NT Government, *Voluntary Assisted Dying Independent Expert Panel - Final Report* (2024), p. 72.
[484] *Voluntary Assisted Dying Act 2021* (SA), s 64 (C); *Voluntary Assisted Dying Act 2021* (QLD), s 50(2); *Voluntary Assisted Dying Act 2017* (Vic), s 46(c).
[485] *Voluntary Assisted Dying Act 2022* (NSW), ss 59 and 60; *Voluntary Assisted Dying Act 2024* (ACT), s 42; *Voluntary Assisted Dying Act 2019* (WA), s 56
[486] NSW Voluntary Assisted Dying Board, *Annual Report 2023-2024* (2024), p. 15; Voluntary Assisted Dying Board Western Australia, *Annual Report 2023-24* (2024), p. 28.
[487] *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas), s 86(1)(a).

person. A comparison of the legal framework and the rates of VAD method of administration is set out in Figure 15.

Figure 15: Legal Frameworks and Rates of VAD Method of Administration by Jurisdiction[488]

Jurisdiction (year entered into force)	Availability of self-administration	Availability of practitioner administration	Rate of self-administration	Rate of practitioner administration
Victoria (2019)	Default method	Only available if the person is physically incapable of self-administration or digestion of the VAD substance.	85.0%	15.0%
Western Australia (2021)	Default method	Only available if self-administration is inappropriate for the person because of their ability to self-administer, their concerns about self-administration, and/or the method.	19.7%	80.3%
Tasmania (2022)	Private self-administration (ie, unsupervised self-administration as per other states) is the default method. If private self-administration is inappropriate because of the person's ability to self-administer, their concerns about self-administration, or the method, then the person may have supervised self-administration or assisted self-administration.	Only available if self-administration is inappropriate for the person because of the person's ability to self-administer, their concerns about self-administration, and/or the method.	Not reported	Not reported
South Australia (2023)	Default method	Only available if the person is physically incapable of self-administration or digestion of the VAD substance.	85.5%	14.5%
Queensland (2023)	Default method	Only available if self-administration is inappropriate for the person because of their ability to self-administer, their concerns about self-administration, and/or the method.	33.5%	66.5%
New South Wales (2023)	Patient's choice	Patient's choice	29.7%	70.3%
Australian Capital Territory (2025)	Patient's choice	Patient's choice	No data reported yet (Act not operational)	No data reported yet (Act not operational)

Evidence before the Committee

8.10 Many stakeholders to the Inquiry supported enabling individuals to make decisions about how they would like to administer the VAD Substance,[489] giving individuals greater options for choosing the time and place they administer the VAD Substance. In general, stakeholders expressed that administration should be a decision between a person and their Coordinating Practitioner. The Northern Territory Voluntary Euthanasia Society stated:

> The nature of the assistance to be provided and who will administer the VAD substance should be negotiated between the person and their doctor.[490]

[488] E. Close, K. Del Villar and B. P. White, 'Should self-administered voluntary assisted dying be supervised? A Queensland case' (2025), *Medical Journal of Australia* 222(8), pp. 390-393.
[489] Submissions 83, 203, 125.
[490] Submission 83.

8.11 Some stakeholders noted that there was a possibility that Practitioner Administration could allow room for coercion to choose VAD. In these instances, stakeholders suggested Self-Administration was a good alternative to prevent coercion. [491]

8.12 Several stakeholders highlighted the need for a range of Self-Administration options, including methods beyond oral ingestion. This would ensure access for individuals who are unable to swallow or who may have other physical limitations, therefore requiring intravenous delivery.[492]

8.13 However, some stakeholders raised concerns about the potential risks associated with Self-Administration, suggesting that:

- unsafe storage of the VAD Substance could lead to an increased suicide rate in remote communities where this is already a concern;[493]
- errors in Self-Administration could inadvertently involve emergency responders, including ambulance services, who do not wish to be involved in VAD;[494] and
- swallowing assessments need to be conducted prior to medication administration, to ensure the appropriate administration route is chosen.[495]

8.14 In remote communities, stakeholders suggested additional supports would be required from ACCHOs. In Barkly Regional Council Mayor, Sid Vashist stated:

> [S]elf-administration is something that needs to be done hand in hand, mandated, if it is our communities by ACCHOs and the introduction of Aboriginal health practitioners.[496]

8.15 In light of these concerns, it was suggested appropriateness of a Self-Administration decision should be assessed on a case-by-case basis.[497] Further, to counteract potential risks, some stakeholders suggested the option of supervised Self-Administration, whereby a person self-administers the VAD Substance under the supervision of a health practitioner.[498] For example, Marshall Perron, former NT Chief Minister, stated:

> The ultimate safeguard that would make an NT VAD regime safe and efficient would be a requirement that a medical practitioner be present when lethal medication is to be self administered. Such a provision ensures the process goes as planned and resolves issues regarding the storage, transport and return of drugs. It also ensures anyone present is informed regarding the process and what to expect. The doctor could also issue the death certificate. The NT Rights of the Terminally Ill Act required the doctor to be present when an applicant self-administered the lethal substance and remained present until death occurred. Only Tasmania requires a doctor to be present during self-administration.

[491] Submission 154.
[492] Submission 83, 203.
[493] Submission 18.
[494] Submission 166.
[495] Submission 182.
[496] Meeting with Barkly Regional Council and Tennant Creek Local Authority, Tennant Creek, 27 August 2025.
[497] Submissions 83, 125.
[498] Submission 91.

> This is intended to avoid mishaps where the doctor can take appropriate action. (Attendance can be avoided by application if the patient is deemed capable to self-administer.)[499]

8.16 Despite these suggestions, the Committee notes supervised Self-Administration may place additional burdens on the healthcare system, as Dr Eliana Close, Dr Katrine Del Villar and Professor Ben White, from the Queensland University of Technology (QUT), note:

> Supervised self-administration will ask more of VAD practitioners, who already have heavy workloads and lack adequate remuneration, potentially creating further system sustainability issues. Supervised self-administration may result in more people choosing practitioner administration, given the primary benefit to the patient of self-administration (to choose precise timing) is diminished. As the coroner noted, VAD practitioners may be asked to supervise patients outside of typical hours (eg, at sunset or on the weekend), which would further stretch an already busy workforce. Burdens on clinicians would be intensified in jurisdictions with a small VAD workforce.[500]

8.17 Some witnesses noted that cultural considerations was impact on a person's Administration Decision. Regarding the question of where VAD administration should occur, a regional nurse noted it may be difficult to allow administration on site at:

> [In this community], which is quite small, your staff cohort may not be comfortable with that happening in here, but then with cultural considerations of place, it might actually be where people want to enact it because they do not want their home to have that connotation, especially if they have living family members who will remain in that home post their death.[501]

Committee comments

8.18 The Committee recognises that providing individuals with choices about the administration of the VAD Substance can offer a sense of autonomy and dignity in determining the place, time, and manner of their death. Over time, VAD laws across Australia have increasingly focused on empowering patients with greater control over these decisions.

8.19 The Committee notes that discussions about the preferred method of administration may begin during the First Assessment and may evolve as circumstances change. It is therefore important that individuals have the ability to revoke or amend their Administration Decision at any stage, with clear processes for the return, replacement, or secure supply of the VAD Substance as required. Refer to the Supply, storage and disposal' section below for further discussion on this issue.

8.20 While the Committee recognises concerns raised about Self-Administration, particularly in remote and vulnerable communities, it considers that Self-Administration should be an option in the NT. Noting the pressure it may place on individuals and the shortage of health practitioners, the Committee does not consider supervised administration to be a workable alternative.

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[499] Submissions 35, 84.
[500] E. Close, K. Del Villar and B. P. White, 'Should self-administered voluntary assisted dying be supervised? A Queensland case' (2025), *Medical Journal of Australia* 222(8), pp. 390-393.
[501] Meeting with staff member at Tennant Creek Hospital, Tennant Creek, 28 August 2025.

8.21 It is important that the legislation includes a requirement that when a person revokes a Self-Administration Decision, the VAD Substance must be returned and/or disposed if already supplied to the person before the person can make a new Administration Decision. This is to avoid a situation in which a person may still be in possession of a VAD Substance intended for Self-Administration at the time of Practitioner Administration. The Committee recommends a new provision that the VAD kit supplied for Self-Administration must be returned where Practitioner Administration will occur, which is intended to prevent misuse of a VAD Substance intended for Self-Administration.

8.22 Decisions about whether Self-Administration is appropriate must be made on a case-by-case basis, in consultation with the Coordinating Practitioner. In making this determination, the practitioner should balance an individual's right to choice with practical considerations such as the person's capacity to safely self-administer, and the secure storage, supply, and disposal of the VAD substance in the community. The Committee considers that these decisions should be reported to the Review Board.

8.23 Although not making a formal recommendation, the Expert Panel supported a person's right to choose between Self-Administration and Practitioner Administration.[502] The Panel emphasised that safe supply, storage and disposal of the VAD substance for Self-Administration are important considerations in the NT.

8.24 The Committee supports the view that a person should be able to choose between Self-Administration and Practitioner Administration. Measures should be included in the legislation to ensure the safety of the VAD substance in the community. For example, the Committee's view is that a person seeking Self-Administration should only be supplied with one VAD kit at a time with the goal of preventing misuse of a VAD substance intended for Self-Administration.

8.25 In some cases, a person may make a Self-Administration Decision but wish to have a healthcare worker present at the time of Self-Administration. Their role may be simply being present at the time, or assisting the person to prepare – for example, dilute or decant – the VAD substance, though the person must still self-administer the VAD substance themselves. This wish should be discussed at the time the person makes an Administration Decision. The drafting instructions include provisions which support a person's ability to have a healthcare worker present at the time of Self-Administration.

Making an Administration Decision

Recommendation 30

The Committee recommends that the legislation should provide that:

a. A person who has completed the request and assessment process may make an Administration Decision in consultation with and on the advice of their Coordinating Practitioner. An Administration Decision can be communicated by

[502] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 72.

the person to their Coordinating Practitioner verbally, by gestures, or other means.

b. An Administration Decision must be:

i. made by the person (not another person on their behalf); and

ii. clear and unambiguous.

c. An Administration Decision must be able to be revoked by the person by communicating this to their Coordinating Practitioner verbally, by gestures, or other means. If an Administration Decision is revoked, the person must be able to make a new Administration Decision. If a person who has made a Self-Administration Decision has been supplied with a VAD kit, a new Administration Decision cannot be made until that VAD kit has been returned to an authorised disposer.

d. The Coordinating Practitioner and/or Administering Practitioner should notify the Review Board if a person makes or revokes an Administration Decision within two business days and include this information in the person's medical record.

Choice of method of administration

Recommendation 31

The Committee recommends that legislation should provide that:

a. The person can choose either Self-Administration or Practitioner Administration. This decision should be made on the advice of, and in consultation, with the person's Coordinating Practitioner.

b. An Administration Decision may only be made after specific consideration is given by the person and their Coordinating Practitioner to:

i. the ability of the person to self-administer the substance;

ii. the person's concerns about methods of administration;

iii. the method of administration that is suitable to the person; and

iv. the ability to ensure the safe supply, storage and disposal of the VAD substance if present in the community.

c. A person who makes a Self-Administration Decision may request to have a healthcare worker present at the time of Self-Administration. This should be discussed when a Self-Administration Decision is made. As part of this discussion, where a healthcare worker has agreed to be present, their role should be explained to the person, including that the healthcare worker is permitted to assist in preparing the VAD Substance for Self-Administration, but is not permitted to administer the VAD Substance to the person.

d. The decision to have a healthcare worker present for Self-Administration must be documented in writing in the approved form.

Contact Person

8.26 A Contact Person is a role established in VAD legislation across Australia. They have responsibilities connected with the storage and disposal of the VAD Substance and reporting of the death of the person, whether or not the death was as a result of administration of the VAD Substance or another cause.

8.27 The 2024 Expert Panel Report recommended that a Contact Person should be appointed by a person who elects Self-Administration for VAD.[503] The Expert Panel also raised that the role of a Contact Person "may present extremely significant cultural challenges within some families or communities, where that person could be believed to be responsible for the VAD recipient's death".[504]

8.28 The Committee supports Recommendation 17 of the 2024 Report in relation to the appointment of a Contact Person for Self-Administration Decisions. The Report does not mention appointment of a Contact Person in cases of Practitioner Administration.

Approaches in other jurisdictions

8.29 In other jurisdictions, the Contact Person may be anyone over the age of 18. They must certify that they understand and accept their obligations and that the Review Board may ask them for information in relation to the VAD case.[505] The Contact Person may receive, possess and supply the VAD Substance. However, the VAD recipient must take the VAD Substance themselves. The Contact person must also return the VAD Substance whether used or unused to the dispensing pharmacy.

8.30 In the ACT and NSW, the responsibilities of the Contact Person are broader, enabling them to also assist with preparing the VAD Substance.[506] The Committee notes there is some evidence in other jurisdictions of the benefits of the Contact Person being allowed to assist with preparing the VAD Substance. For example, the WA VAD Review Board's *Annual Report 2021-22* stated:

> If the patient is unable to independently undertake these actions or is concerned about their ability to undertake these actions, self-administration is not a suitable option and a practitioner administration decision is made to assist with these actions. It is recommended that section 58 of the *Voluntary Assisted Dying Act 2019* be expanded for the Contact Person or other nominated person to be able to assist the patient in the preparation of the prescribed substance when self-administration is preferred by the patient.[507]

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[503] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), Recommendation 17.

[504] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 126.

[505] See for example, *Voluntary Assisted Dying Act 2017* (Vic), ss 39 and 40. In WA the Contact Person does not have to certify on the appointment form that they understand that the Review Board may ask them for information in relation to the subject VAD case. Section 150 of the *Voluntary Assisted Dying Act 2019* (WA) permits the Board to request a person (including the Contact Person) to give information to the Board to assist the Board in performing its functions. However this is not part of the certification by the Contact Person on appointment. See *Voluntary Assisted Dying Act 2019* (WA), Division 3.

[506] *Voluntary Assisted Dying Act 2024* (ACT), s 51(3).

[507] WA VAD Review Board, *Annual Report 2021-22*, p. 39.

8.31 Some jurisdictions (for example, WA and Tasmania) require the appointment of a Contact Person only for Self-Administration and other jurisdictions require this for Practitioner Administration as well (for example, Victoria).[508]

8.32 The main reasons for requiring a Contact Person for Self-Administration decisions, as explained in the Queensland context, are to "assist the person throughout the process, ensure there is accountability for the substance once the person either dies or decides not to self-administer the substance and provide a point of contact for the [Review] Board". The main reason for requiring a Contact Person for a practitioner administration decision is to "provide a point of contact for the [Review] Board". [509]

Evidence before the Committee

8.33 There was evidence presented to the Committee noting that a person could be blamed or receive payback if they do not follow cultural protocols. For example, a community representative from Borroloola stated:

> I am going back here, because, like I said, people… very educated, but there is always that blame that needs to go on somebody. If you do not follow Indigenous protocol and you may step out of line, you could be in trouble… making decisions instead of… whole mob, sort of thing, you could be the one to blame.[510]

The Committee notes that although this evidence was not specifically linked to the role of the Contact Person, it should be considered that a Contact Person may be negatively impacted by taking up this role, as raised by the 2024 Expert Panel Report.[511]

8.34 Many submitters supported the appointment of a Contact Person only for Self-Administration.[512] A number of submissions suggested more stringent requirements for who can be a Contact Person, referencing a Queensland Coroner's Court Inquest involving the rare misuse of the VAD Substance by a Contact Person.[513]

8.35 Some submitters suggested there may be a need for additional safeguards to prevent the misuse of the VAD Substance.[514] For example, Dying with Dignity Queensland suggested to "implement robust contact-person screening and self administration protocols" and "incorporate reforms to address Coroner-identified risks—such as suitability checks for 'contact persons'".[515] However, the Committees notes that no submissions provided specific recommendations for what a suitability check might entail.

8.36 There was some discussion about whether a Contact Person is required. For example, Christians Supporting Choice for Voluntary Assisted Dying suggested that the

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[508] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 352.
[509] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 355.
[510] Meeting with Mabunji Aboriginal Resource Indigenous Corporation, Borroloola, 7 August 2025.
[511] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 126.
[512] Submission 125.
[513] Submissions 91, 98, 333.
[514] Submission 101.
[515] Submission 91.

Administering Practitioner can perform the role of the Contact Person, so a separate Contact Person is not needed.[516] However, the Committee notes that, in the case of Self-Administration, there is no Administering Practitioner to be able to perform this role.

8.37 Go Gentle Australia supports a middle ground where a Contact Person is only required if a person chooses Self-Administration, as the Administering Practitioner can undertake the role of the Contact Person in the case of Practitioner Administration:

> Go Gentle recommends the NT adopt the provisions contained in other states' VAD legislation regarding the confirmation of use and the safe return of any unused VAD substances – namely that the coordinating or administering practitioner be required to notify the VAD Board of the use of the medication and the disposal of any unused substances (in the case of practitioner administration) and that a contact person be appointed who is responsible for notifying the coordinating practitioner of the VAD death and returning any unused substances (in the case of self-administration) to the designated authority (eg; a central pharmacy).[517]

8.38 The Committee notes that Go Gentle Australia's additional recommendation that the Coordinating Practitioner or another qualified health professional be able to return any unused substance on the contact person's behalf is addressed at Recommendation 33(c)(i) below.[518]

8.39 The Committee heard that the Contact Person should be able to assist with preparing the VAD Substance. In relation to the WA legislation, Professor Lindy Willmott, Professor Ben White and Dr Casey M Haining stated:

> It is desirable for a patient to be permitted to receive assistance to prepare the VAD substance if this help is wanted. This is allowed in other jurisdictions and there is no evidence that this kind of assistance compromises the voluntariness of the patient's choice to take the VAD substance.[519]

Committee comments

8.40 The Committee is of the view that the Administration Decision process and the safe supply, storage and disposal process should provide adequate protections and safeguards for individuals and the community while supporting the autonomy of the person accessing VAD.

8.41 The Committee recognises the cultural challenges that the role of the Contact Person may present in some remote communities. This should be considered in the development of policy and guidelines.

8.42 The Committee considers that a Contact Person may be negatively impacted by taking up this role, as raised by the 2024 Expert Panel Report.

8.43 The Committee finds that official appointment of a Contact Person for Practitioner Administration is unnecessary as, in the proposed NT model, the drafting instruction

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[516] Submission 71.
[517] Submission 203.
[518] Submission 203
[519] Australian Centre for Health Law Research, L. Willmott, B. P. White and C. M. Haining, *Review of the Voluntary Assisted Dying Act 2019 (WA): Research Report* (2024), p. 133.

provides for the Administering Practitioner to complete the responsibilities a Contact Person otherwise would.

8.44 The Committee notes that in the ACT and NSW, the Contact Person can prepare the VAD Substance, and in WA the VAD Review Board recommended amending the *Voluntary Assisted Dying Act 2019* (WA) to enable this. The Committee supports adopting this model so as not to create an unnecessary barrier to Self-Administration for those who would prefer this option.

8.45 The Committee is of the opinion that the other requirements and roles of the Contact Person should be consistent with the Australian model of VAD.

Recommendation 32

The Committee recommends that the legislation should provide that:

- **a. A person who has made a Self-Administration Decision must appoint a Contact Person aged 18 years or over. This appointment should be made in the approved form and contain the prescribed information. The Coordinating Practitioner must notify the Review Board of the Contact Person appointment within two business days after receiving the appointment form.**
- **b. A new Contact Person must be appointed if the original Contact Person is unable or unwilling to continue in the role.**
- **c. A person who accepts the role of Contact Person must certify that they understand and accept their legal obligations as Contact Person. One of these legal obligations is to provide information if requested by the Review Board.**
- **d. Within two business days of receiving the Contact Person appointment form, the Review Board must give the Contact Person information about their obligations as a Contact Person and support services available to the Contact Person in relation to their obligations.**
- **e. A Coordinating Practitioner may not prescribe a VAD Substance for a person who has made a Self-Administration Decision before the Contact Person appointment form has been given to the Coordinating Practitioner.**

Where a person has made a Self-Administration Decision

Recommendation 33

The Committee recommends that the legislation should provide that where a person has made a Self-Administration Decision:

- **a. If impracticable for the person to do so themselves, the Contact Person is legally permitted to receive, possess, handle, prepare, and supply the VAD substance to the person.**
- **b. Only the person can administer the VAD substance to themselves for Self-Administration.**
- **c. The Contact Person has legal obligations to:**
  - **i. provide any unused or remaining substance to an authorised disposer;**

ii. report the person's death; and

iii. provide information to the Review Board if requested.

Authorisation of VAD administration

8.46 In Australia, the process of approval and administration of VAD diverges between jurisdictions following the Formal Request step.[520] One such variation is whether there is a requirement to be granted a permit to access VAD or not.

8.47 A VAD permit sets out what the Coordinating Practitioner, the person accessing VAD and the Contact Person are then authorised to do, such as prescribe and supply the VAD Substance, self-administer the VAD Substance and return the VAD Substance to the pharmacist.

8.48 The 2024 Expert Panel Report recommended that the VAD process should not require the issuing of a permit but rather allow the Coordinating Practitioner to approve the request and issue a prescription, subject to strict reporting requirements.[521] This was proposed to ensure there is respect of the autonomy of the person seeking VAD.[522]

8.49 The Committee supports Recommendation 16 of the 2024 Report.

Approaches in other jurisdictions

8.50 In Victoria and SA there is a requirement for medical practitioners to apply for a Self-Administration permit or a Practitioner Administration permit from the Review Board or Commission, or from the relevant department CEO to access VAD.[523] The policy rationale for permits is:

> …to establish clear monitoring and accountability for the safe prescription of the lethal dose of medication for voluntary assisted dying.[524]

8.51 Other jurisdictions leave the management of the process to the Coordinating Practitioner, subject to strict reporting requirements to the Review Board.[525] For example, in WA, decisions are made in consultation with and on the advice of the Coordinating Practitioner to support autonomy and align with principles of person-centred care.[526]

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[520] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 70.
[521] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), Recommendation 16.
[522] *NT Government, Voluntary Assisted Dying Independent Expert Panel, Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024 (2024),* p. 70.
[523] *Voluntary Assisted Dying Act 2017* (Vic), s 45 and 46; *Voluntary Assisted Dying Act 2021* (SA), ss 63 and 64.
[524] Victorian Government, *Ministerial Advisory Panel on Voluntary Assisted Dying - Final Report* (2017), p. 134.
[525] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 70.
[526] Queensland Law Reform Commission, *A Legal Framework for Voluntary Assisted Dying* (2021), p. 288.

Evidence before the Committee

8.52 Evidence submitted to the Committee stated that permits should not be required for VAD.[527] Shirley Hendy, an NT resident and retired doctor, raised that:

> The process needs to be as streamlined and straightforward as possible. People with a terminal illness become progressively physically tired and weak, often exhausted by pain, and suffering various losses of function in their daily living, as well as drained by coping with hospital and medical appointments, treatments and side effects, and the emotional impacts of loss of independence, and impending death. They do not need to be subjected to a drawn out, cumbersome, bureaucratic process.[528]

8.53 Professor Ben White and Professor Lindy Willmott similarly noted:

> Delays associated with the process of applying for and accessing VAD. Medical practitioners can be frustrated when they have to wait for a permit to access VAD and when forms submitted to the relevant oversight body are rejected as this causes delays for patients, who have already been assessed as experiencing intolerable suffering.[529]

8.54 Other jurisdictions are increasingly questioning the utility of the permit system. In their submission, Dying with Dignity Victoria pointed to the inadequacies in the Victorian permit system:

> We support the NT's proposal to consider alternatives to the bureaucratic permit process that Victoria adopted. Many Victorians have died suffering while awaiting the completion of this time-consuming, unnecessary step in the VAD process. The Victorian Government has announced its intention to simplify the permit process to improve applicant choice and prevent delays due to permit change.[530]

8.55 These claims are reflected in annual reports in other jurisdictions. The Committee notes the Victorian VAD Review Board's 2021-22 Annual Report reported a large number of errors in permit applications which resulted in delays.[531]

Committee comments

8.56 Whilst noting the policy rationale for requiring permits, the Committee observes that research has found the permit system to be bureaucratic and a cause of unnecessary delay considering the many other safeguards in place.[532]

8.57 The Committee finds that decision-making about VAD should occur between the person and their Coordinating Practitioner to respect the autonomy of the person seeking VAD.

8.58 The Committee considers that notification to the Review Board and requirements for the VAD substance prescription provides appropriate and adequate safeguards.

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[527] Submissions 55, 71, 83, 108, 125.
[528] Submission 55.
[529] Submission 5
[530] Submission 125.
[531] Victorian Voluntary Assisted Dying Review Board, *Annual Report 2021-22* (2022), p. 12-13.
[532] Victorian Voluntary Assisted Dying Review Board, *Annual Report 2021-22* (2022), p. 12-13.

Recommendation 34

The Committee recommends that the legislation should provide that the person's Coordinating Practitioner must, within two business days of the prescription being issued, notify the Review Board that the person has been assessed as eligible for VAD, made an Administration Decision and that a VAD Substance prescription has been issued.

VAD prescription

Recommendation 35

The Committee recommends that a prescription issued for VAD must:

a. Contain a statement that:

i. it is issued to authorise the prescription of a VAD Substance;

ii. the prescribing Coordinating Practitioner certifies that the request and assessment process has been completed for the person in compliance with the legislation;

iii. the prescribing Coordinating Practitioner certifies that the person has made an Administration Decision (either Self-Administration or Practitioner Administration);

iv. provides the details of the VAD Substance and the maximum amount of the substance authorised by the prescription; and

v. any other information provided by the Regulations.

b. Be in the approved form;

c. Not provide for the VAD Substance to be supplied on more than one occasion; and

d. Be given by the Coordinating Practitioner directly to an authorised supplier.

Supply, storage and disposal

8.59 A key issue for the NT is to ensure the safe supply, storage, and disposal of the VAD Substance to prevent unintended harm to the person seeking VAD and the community, noting that the VAD Substance is designed to be lethal. This needs to be balanced with timely access to VAD.

8.60 The 2024 Expert Panel Report recommended the legislation should provide for safe supply, storage and disposal of the substance, including a Contact Person for VAD. However, it did not specify how this might be achieved. One approach briefly canvassed in the Report was to require the person or their Contact Person to collect the VAD substance from the authorised supplier at the time of Self-Administration

rather than store it in a domestic environment.[533] However, the Committee notes this approach may:

- impair the person's ability to self-administer at a time of their choosing;
- be onerous for the person, or Contact Person; and
- be impracticable given the distance and time that this may involve, particularly for people living in remote areas.

8.61 The 2024 Expert Panel Report proposed that, in the NT, the pharmacist would verify the validity of the supply request and be satisfied that all criteria have been met before providing information to the person and dispensing the VAD Substance.

8.62 The 2024 Expert Panel Report discussed whether requirements for storage should be included in primary legislation or better left to delegated legislation or policy guidelines.[534]

8.63 A requirement that is important to include in the legislation is that a person should only be supplied one VAD kit at any time. This means that where a Self-Administration Decision is revoked, if the VAD substance for Self-Administration has already been dispensed, it must be returned and/or disposed of before a new Practitioner Administration Decision can be made.

8.64 In the 2024 Expert Panel Report the eligible person accessing VAD would be responsible for maintaining the supplied substance in a safe and secure way. The appointed Contact Person would be notified of the secure storage location of the supplied substance and entitled to possess any unused portion of the VAD substance and supply it to an authorised disposer.

8.65 The Committee adopts Recommendation 17 of the 2024 Report in relation to the safe supply, storage and disposal of the VAD substance.

Approaches in other jurisdictions

Supply

8.66 In other States, the pharmacist is required to provide information that is similar to the information required to be provided by the Coordinating Practitioner before prescribing the VAD Substance.[535] Additionally, the pharmacist is required to verify all aspects of the prescription, including verifying the prescribing health practitioner's eligibility as a Coordinating Practitioner under VAD legislation.[536] For example, in WA, the authorised supplier must not supply the VAD Substance unless they have

[533] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 73-74.
[534] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 73.
[535] For example, *Voluntary Assisted Dying Act 2017* (Vic), s 58; *Voluntary Assisted Dying Act 2019* (WA), s 72.
[536] *NT Government*, *Voluntary Assisted Dying Independent Expert Panel*, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 74.

confirmed the authenticity of the prescription, the identity of the person who issued it and the identity of the person to whom the VAD Substance is to be supplied.[537]

Storage and disposal – Self-Administration

8.67 All jurisdictions except WA and the ACT legislated that the VAD Substance must be stored in a locked box.[538] While not specified in the legislation, in the ACT the VAD Substance must be stored in a locked box according to Regulation 27s. For example, in Victoria, the VAD Substance must be stored by the person in a locked box constructed of steel, that is "not easily penetrable" and "lockable with a lock of sturdy construction".[539] The WA legislation only has a requirement to inform the recipient how to store the VAD Substance safely and securely.[540]

Storage and disposal – Practitioner Administration

8.68 In other jurisdictions, if the VAD Substance is issued to an administering practitioner, they must:

- notify the Review Board that they have received the prescription;
- either safely dispose of, or return, the substance to the pharmacist; and
- notify the Review Board of the return and disposal of the substance.[541]

Evidence before the Committee

8.69 The Committee heard a range of views on the appropriate approaches to supplying, storing and disposing of the VAD Substance. The majority of this evidence focused on regional and remote communities.

Supply

8.70 The Committee did not receive any specific evidence about requirements for pharmacists to verify aspects of the prescription.

8.71 The Committee was advised of the potential logistical challenges associated with supplying the VAD Substance in remote communities. Voluntary Assisted Dying Australia and New Zealand stated this called for more community pharmacy involvement in the VAD process:

> We believe there should be other pharmacies that are authorised to dispense and accept returned VAD substance that is accessible to all people. Relying on a single pharmacy source can result in unnecessary delays and pharmacist workforce

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[537] *Voluntary Assisted Dying Act 2019* (WA), s 71.

[538] *Voluntary Assisted Dying Act 2018* (Vic), s 57(c); *Voluntary Assisted Dying Act 2022* (NSW), s 79; Voluntary Assisted Dying Regulation 2022 (Qld), reg 7; *Voluntary Assisted Dying Act 2021* (SA), s 78; *End-of-Life Choices (Voluntary Assisted Dying) Act 2021*, s 73(1). Note the ACT provides for the storage of the VAD substance to be prescribed by regulation. At time of publication not storage requirements have been prescribed. See *Voluntary Assisted Dying Act 2024* (ACT), s 74.

[539] *Voluntary Assisted Dying Act 2017* (Vic), s 61; Voluntary Assisted Dying Regulations 2018 (Vic), regulation 10.

[540] *Voluntary Assisted Dying Act 2019* (WA), s 72(2)(b).

[541] See, for example, *Voluntary Assisted Dying Act 2019* (WA), ss 60, 77 and 78.

> issues. Returning to a central pharmacy is not always reasonable for patients or their grieving families.[542]

8.72 Professor Lindy Willmott and Professor Ben White, in a study undertaken with Dr Casey M Haining regarding the WA legislation, noted the inability to use electronic prescriptions for the VAD Substance due to the restrictions in the Commonwealth Criminal Code. This may restrict remote and regional residents if scripts are required to be delivered in hard copy.[543] The Committee further notes the person is restricted from asking questions about their VAD prescription via phone.

8.73 The Pharmacy Guild of Australia Northern Territory Branch (PGNT) recommended the need to recognise the role community pharmacists should play in designing VAD services:

> In our position statement, the Guild recognises VAD as an option that some people may choose. It also recognises community pharmacists as responsible custodians of medicines and that, where the laws allow, some community pharmacies could provide VAD services and manage the storage and supply of VAD medicines.
>
> In such circumstances, the competence of community pharmacists to dispense VAD medicines professionally and compassionately for their patients should be recognised in the design, implementation, or review of VAD healthcare services. Involving community pharmacists in VAD service design may increase the accessibility of the service in rural and remote areas.
>
> The PGNT expects community pharmacies involved in VAD services to have the appropriate clinical governance and quality assurance arrangements in place to ensure the safe, confidential and professional provision of VAD services. We also expect these pharmacies to ensure all staff are culturally aware and responsive to the specific needs of First Nations people with regard their end-of-life care preferences and services.[544]

Storage

8.74 In general, stakeholders supported the storage requirements applied in other jurisdictions. Dr Kane Vellar, NT Health, stated that the storage recommendations set out in the 2024 Expert Panel Report are appropriate as:

> That significantly aligns with all other jurisdictions ensuring very robust storage requirements and significant consequences if those practices are not monitored appropriately.[545]

8.75 In particular, there is support for the use of a locked box to store the VAD Substance, consistent with other jurisdictions.[546] The Committee did not receive advice as to whether this requirement should be specified in primary, or delegated, legislation, or in policy.

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[542] Submission 336.
[543] Australian Centre for Health Law Research, L. Willmott, B. P. White and Casey M Haining, *Review of the Voluntary Assisted Dying Act 2019 (WA): Research Report* (2024), p. 118.
[544] Submission 167.
[545]NT Health, Public Hearing, Darwin, 5 August 2025.
[546] Submission 402, 108.

8.76 The Committee heard safety concerns about storing the VAD Substance in remote communities.[547] Stakeholders in remote communities pointed to the need for "checks and balances"[548] and a "stringent process for [the VAD Substance] to be returned to the pharmacy if they did not use it".[549]

8.77 Some remote stakeholders noted that there are existing processes for the storage of dangerous substances in remote and regional pharmacies, and they did not have concerns.[550] For example, the CEO of the Northern Territory Cattlemen's Association explained the existing arrangement on properties of storing potentially dangerous medication in locked boxes – known as a 'white box'.[551]

8.78 Similarly, the PGNT stated pharmacies already safely store and supply a range of substances that are dangerous if used inappropriately and pharmacists have legal and professional obligations to ensure safe storage. PGNT described how local pharmacies could take part in VAD:

> There needs to be clear instructions to the community pharmacy as to whom any supply is to be made, whether to a health practitioner who will be responsible for administering the medicine or to a family member or carer if it is to be self-administered. To minimise any public risks, the collection or delivery arrangements from the community pharmacy should ideally be on the proposed day, with arrangements also in place for the return and disposal of any unused VAD medicine. Consideration otherwise will be needed if the pharmacy is not located in close proximity, such as with remote communities. In such a case, delivery from a pharmacy may need to be to the local health clinic, subject to their willingness to participate.[552]

Disposal

8.79 Some stakeholders supported the role of a centralised pharmacy service in facilitating the safe disposal of the VAD Substance. The Pharmaceutical Society of Australia (PSA) recommended a requirement to return any used or unused VAD Substance to the pharmacy service, noting:

> Considerations about environmental risk and public safety with inappropriate disposal of any medicine can be mitigated with a dedicated pharmacy service to appropriately return and destroy unused VAD substance and medicines that are no longer needed by a patient.[553]

8.80 In contrast, PGNT suggested there may be roles for community pharmacies in the disposal of the VAD Substance:

> Consideration needs to be given to how this will be managed to avoid any unexpected or onerous administrative burden on a local community pharmacy needing to manage the return of unused VAD medicines.

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[547] Submissions 18, 57; Meeting with Barkly Regional Council and Tennant Creek Local Authority, Tennant Creek, 27 August 2025.
[548] Meeting with Barkly Regional Council and Tennant Creek Local Authority, Tennant Creek, 27 August 2025.
[549] Meeting with staff member at Tennant Creek Hospital, Tennant Creek, 28 August 2025.
[550] Meeting with Tennant Creek Mob Aboriginal Corporation, Tennant Creek, 28 August 2025.
[551] Meeting with Cattlemen's Association, Tennant Creek, 28 August 2025.
[552] Submission 167.
[553] Submission 402.

> In Queensland, community pharmacies are recognised as authorised disposers of VAD medicines. PGNT do not oppose this arrangement being implemented in the NT, however, pharmacy should be appropriately recompensed for completion of any additional administrative requirements beyond what is required for disposal of other medicines. It is also important that, should unused VAD medicines be inadvertently returned to a local community pharmacy, there is no liability or penalty for either the community pharmacist or the family members/carers returning the medicine. [554]

8.81 PGNT further noted there are existing programs to support a Contact Person with the return and disposal of the VAD Substance, including the Federal Return of Unwanted Medicines (RUM) Program.

Committee comments

8.82 The Committee considers that there is a need to identify solutions that are appropriate for the NT in relation to the safe delivery, dispensation, storage and use of a VAD substance in the community, especially in remote communities.

8.83 The Committee notes that prescription is an important part of the administration process that happens before supply and after the Administration Decision. To align with other jurisdictions, the Committee considers it is important that the prescription process is included in the legislation as a further safeguard and opportunity for the Review Board to be notified about individual cases.

8.84 The prescription and supply processes provide important opportunities for the person and others to be informed about administration of the VAD Substance. In the case of the person, receiving this information is vital to ensure informed consent in relation to administration. This is consistent with other jurisdictions.

8.85 The Committee notes that, while some requirements relating to the supply, storage and disposal of the VAD substance should be included in legislation, other requirements are more effectively governed by delegated legislation, medication protocols and/or organisation-specific guidelines. The Committee notes that this may enable greater flexibility with the best approach developed in consultation with community pharmacies during the implementation phase.

Recommendation 36

The Committee recommends that the legislation should provide:

a. For the following definitions:

i. authorised supplier — registered health practitioner(s) authorised to supply VAD Substances by the CEO; and

ii. authorised disposer — registered health practitioner(s) authorised to dispose of VAD Substances by the CEO.

[554] Submission 167.

b. That regulations and other protocols will be developed in relation to the prescription, supply, storage and disposal of the VAD Substance and these must be adhered to throughout the administration process.

c. That the person must be given written information about the VAD Substance and other matters relevant to administration – including how to self-administer and store the VAD Substance (if appropriate) and the expected effects and risks of administration – before the Coordinating Practitioner can prescribe a VAD Substance and after the person has made an Administration Decision.

d. That the authorised supplier must authenticate the prescription before the VAD Substance can be dispensed and supplied. The authorised supplier must not dispense the prescription unless they have confirmed the validity of the prescription, the identity of the person who issued the prescription, and the identity of the person to whom supply of the VAD Substance is being made.

e. That, in the case of Self-Administration, the person to whom the VAD Substance is being supplied should be given information by the authorised supplier.

f. That relevant persons (the Coordinating Practitioner, authorised supplier, the person, the Contact Person, another person who may be present at the time of Self-Administration, and the Administering Practitioner) must have relevant authorisations after an Administration Decision is made (to allow prescribing, receiving, possessing, preparing, and supplying the VAD Substance to the person, as relevant). Only the person themselves is authorised to self-administer the VAD Substance.

g. That, where a person has made a Self-Administration Decision, the person must ensure that the VAD Substance is stored in a safe and secure way, according to the Regulations.

h. That the Contact Person is responsible for returning the VAD Substance to a person authorised to dispose of the VAD Substance (authorised disposer) within two business days where the person has:

i. Died prior to Self-Administration;

ii. Revoked a Self-Administration Decision; or

iii. Self-Administered the VAD Substance (in case there is any remaining or unused).

i. That both the Administering Practitioner and authorised disposer must safely dispose of unused or remaining VAD Substances as soon as practicable.

Notifications relating to prescription, supply and disposal

Recommendation 37

The Committee recommends that the legislation should provide that the Review Board must be notified in the approved form at each step in the prescription, supply and disposal processes by the relevant person within two business days of each step.

Procedure for administration of the VAD Substance

8.86 In some jurisdictions, a witness is required at the final administration stage of the VAD process, with the aim to provide protections and safeguards for both the VAD recipient and the Administering Practitioner.

8.87 The 2024 Expert Panel Report does not make a recommendation about the procedure for, or witnessing of, Practitioner Administration. The Committee considers that these procedures should be included in the legislation.

Approaches in other jurisdictions

8.88 All Australian jurisdictions, excluding Tasmania, require a witness to be present during Practitioner Administration.[555] In the Victorian context, the rationale for this is:

> When a person self-administers a lethal dose of medication it is a final indication that their decision is voluntary. When a medical practitioner administers a lethal dose of medication there must be a similar final affirmation that the person's decision is voluntary. This concern must be weighed against the need to ensure the process is not too onerous for people who are extremely unwell and suffering at the end of their life.[556]

8.89 In all these jurisdictions, the witness must be 18 years or over.[557] Following administration, the witness and health practitioner must certify the administration process, including the voluntariness of the request. This certification must be provided to the Review Board within two to seven business days.[558]

8.90 In Victoria, WA, SA and NSW, a person must be independent of the Administering Practitioner to be an eligible witness for the administration.[559] In WA, this means the witness cannot be a family member of the Administering Practitioner or be employed or contracted by the Administering Practitioner.[560] In Victoria, this means that the witness must not be an employee at the same health service as the Administering Practitioner.[561] These provisions are in place to ensure there is no conflict of interest.[562] In Victoria:

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[555] *Voluntary Assisted Dying Act 2017* (Vic), s 46; *Voluntary Assisted Dying Act 2019* (WA), s 59(5); *Voluntary Assisted Dying Act 2022* (NSW), s 60; *Voluntary Assisted Dying Act 2021* (SA), s 82; *Voluntary Assisted Dying Act 2024* (ACT), s 66; *Voluntary Assisted Dying Act 2021* (QLD), s 54.

[556] Victorian Government, Health and Human Services, *Ministerial Advisory Panel on Voluntary Assisted Dying Final Report* (2017), p. 141.

[557] *Voluntary Assisted Dying Act 2019* (WA), ss 62(1)–(2); *Voluntary Assisted Dying Act 2017* (Vic), s 65(1); *Voluntary Assisted Dying Act 2021*, (QLD), s 54; *Voluntary Assisted Dying Act 2021* (SA), s 82(a); *Voluntary Assisted Dying Act 2024* (ACT), s 66; *Voluntary Assisted Dying Act 2022* (NSW), s 63(1).

[558] *Voluntary Assisted Dying Act 2019* (WA), s 61(4) – 2 business days; *Voluntary Assisted Dying Act 2017* (Vic), s 66(2) –7 business days; *Voluntary Assisted Dying Act 2021* (QLD), s 55(4) – 2 business days; *Voluntary Assisted Dying Act 2021* (SA), s 83(2) – 7 business days; *Voluntary Assisted Dying Act 2024* (ACT), s 81(2) – 4 business days; *Voluntary Assisted Dying Act 2022* (NSW), s 62(4) – 5 business days.

[559] *Voluntary Assisted Dying Act 2017* (Vic), s 65(1); *Voluntary Assisted Dying Act 2019* (WA), ss 62(1)–(2); *Voluntary Assisted Dying Act 2021* (SA), s 82(b); *Voluntary Assisted Dying Act 2022* (NSW), s 63(2).

[560] *Voluntary Assisted Dying Act 2019* (WA), s 62(2).

[561] Victorian Government, Health and Human Services, *Voluntary assisted dying - Guidance for health practitioners* (2019), p. 61.

[562] Queensland Law Reform Commission, *A Legal Framework for Voluntary Assisted Dying* (2021), p. 190.

> ...the presence of an independent witness provides an additional safeguard to ensure medical practitioners act appropriately and protects the medical practitioner from claims of impropriety.[563]

8.91 There is nothing to preclude a friend, family member or carer from being the witness.

8.92 Tasmania does not require the presence of a witness during administration of the VAD Substance. However, the Administering Practitioner must make a final determination that the person has decision-making capacity and is acting voluntarily within 48 hours prior to the VAD recipient giving final permission. The final permission states that VAD will be provided "as soon as practicable" after that permission is given.[564]

8.93 Overseas jurisdictions, including New Zealand and Canada, have similar provisions to Tasmania. In New Zealand, the Administering Practitioner must first ask the person if they choose to receive the medication prior to administration, and in Canada the Administering Practitioner must immediately before administering, "give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive medical assistance in dying".[565]

Evidence before the Committee

8.94 As outlined in the section 'Formal Request' in Chapter 7, the Committee received evidence that there is a need for flexibility in the requirement for the formal VAD request to be made in writing to accommodate people who cannot physically write and those who, for cultural reasons, need to make the request via an alternative mode. Similar considerations should apply when considering the form of certification required by the witness to administration of the VAD Substance.

8.95 Some submitters stated their support for requiring or allowing a witness to be present at the time of Practitioner Administration.[566] Two submitters raised that the witness should be a person who is independent from the person accessing VAD in that they should not benefit from the person's death[567] or should not have a close relationship to the person accessing VAD or the Administering Practitioner.[568]

8.96 Go Gentle Australia advocated for the opposite approach, arguing that friends or family should be the person's witness at this stage:

> In the case of practitioner administration, Go Gentle recommends a witness, ideally a supportive friend or family member of the patient, be present (where practical) when practitioner administration occurs. This can be reassuring for the person accessing VAD, their family and the administering health professional.[569]

8.97 The Committee notes that no jurisdiction in Australia restricts individuals with a close relationship to the person accessing VAD from being a witness and acknowledges that

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[563] Victorian Government, Health and Human Services, *Ministerial Advisory Panel on Voluntary Assisted Dying Final Report* (2017), p. 144.
[564] Queensland Law Reform Commission, *A Legal Framework for Voluntary Assisted Dying* (2021), p. 314
[565] *End of Life Choice Act 2019* (NZ), ss 20(2)–(4); *Canada Criminal Code*, RSC 1985, c C-46, ss 241.2(3)(h), 241.2(3.1)(k).
[566] Submissions 181, 203, 334.
[567] Submission 334.
[568] Submission 181
[569] Submission 203.

having such a witness present for that person's last moments may be a source of comfort for the person receiving VAD and for their friends and family.

8.98 The Australian Care Alliance also recommended that there be a witness at the time of Self-Administration, to ensure that the VAD Substance is not "surreptitiously or even forcibly administered to a person".[570]

Committee comments

8.99 The Committee notes that no Australian jurisdiction requires a witness in the case of Self-Administration.[571] The Committee is of the view that there are sufficient safeguards throughout the VAD process that ensure a person's choice to access VAD is voluntary, and that a person should be free to choose if they would like others present at the time of Self-Administration or not.

8.100 The Committee finds that the requirement to have a witness for Practitioner Administration provides additional protection for both the person accessing VAD and the Administering Practitioner, without creating additional or unnecessary barriers to accessing VAD at the final stage.

8.101 The Committee agrees that there should be flexibility in the witness certification requirement, similar to the flexibility required for the formal written request for VAD.

8.102 The Committee proposes the eligibility requirements for a witness to the administering decision should align with the majority of Australia jurisdictions by requiring the witness be over 18 years old and be independent from the Administering Practitioner in that the witness is not a family member, employee or contractor of the Administering Practitioner

Recommendation 38

The Committee recommends that, in relation to a person who has made a Practitioner Administration Decision, the legislation should provide:

a. For a definition of an eligible witness to Practitioner Administration - a person who:

i. has reached 18 years of age; and

ii. is not an ineligible witness. A person is an ineligible witness if they:

- **are a Family Member of the Administering Practitioner for the person; or**
- **are employed or engaged under a contract for services, by the Administering Practitioner for the person.**

b. That an eligible witness must be present when a VAD Substance is administered. Following administration, the witness must certify in the approved form that the person was acting voluntarily and without coercion and the Administering

[570] Submission 90.
[571] End of Life Law in Australia, *Voluntary Assisted Dying* (2025), https://end-of-life.qut.edu.au/assisteddying.

Practitioner administered the VAD Substance to them in the presence of the witness.

c. **That an Administering Practitioner who has administered a VAD Substance to a person who made a Practitioner Administration Decision must certify in writing, immediately following administration that:**

   i. **The person made a Practitioner Administration Decision, and did not revoke that decision;**

   ii. **The Administering Practitioner was satisfied at the time of administration that the person had decision-making capacity in relation to VAD; and**

   iii. **The person was acting voluntarily and without coercion.**

d. **That both certifications must be provided to the Review Board within two business days of administration.**

Transfer of Administering Practitioner

8.103 In certain circumstances, an Administering Practitioner may be unwilling or unable to assist with administration of the VAD Substance. This may be because they are sick or on leave.

8.104 Therefore, a process is required to enable the Administering Practitioner to transfer their role to another authorised VAD practitioner if they become unavailable. The Committee notes this may facilitate broader access to VAD via Practitioner Administration.

8.105 The 2024 Expert Panel Report did not make any recommendations about the procedure for transferring the Administering Practitioner's role.

Approaches in other jurisdictions

8.106 In some other jurisdictions, the Administering Practitioner role may be transferred in certain circumstances.[572] Generally, prior to transferring the role, the Administration Decision must have been made, and the Coordinating Practitioner must have prescribed the VAD Substance.

Evidence before the Committee

8.107 The Committee received limited evidence about such transfer. Some stakeholders supported the ability to transfer roles.[573]

8.108 The Committee heard that it is necessary to have a simple process for transferring the role. In a study of the VAD process in WA, Professor Lindy Willmott, Professor Ben White and Casey M Haining noted the process for transferring roles is complex and in need of simplification:

> Participants also identified that the current process for transferring the administering role to another practitioner (whether a medical or a nurse

[572] See, for example, *Voluntary Assisted Dying Act 2021* (Qld), s 56.
[573] Submissions 5, 203.

practitioner) was unnecessarily complex. Participants reported that difficulties commonly arose when the coordinating practitioner was no longer available to administer (eg due to a lack of capacity or being on leave). In such cases, a new administering practitioner could be assigned. However, participants noted that the current processes can be administratively burdensome. Indeed, such cases required the originally assigned administering practitioner to log on to the VAD-IMS to facilitate the transfer. This was considered impractical and challenging at times, particularly in cases when they did not have access to the VAD-IMS when the transfer needed to occur. Similarly, due to the absence of a streamlined transfer process, participants described that difficulties also arose in cases when a transfer of administrating practitioner was made (eg because the patient was expected to take the substance while the original administering practitioner was on leave) but circumstances changed and the original administering practitioner was now able to carry out the administration (eg because they returned from leave).[574]

Committee comments

8.109 Whilst noting the 2024 Expert Panel Report did not make specific recommendations about transferring Administration Practitioner roles, the Committee notes these provisions are present in the legislation of other jurisdictions. The Committee considers it important to enable the transfer of this role, to ensure an eligible person can access VAD even if an Administering Practitioner in unavailable on the chosen date. In light of the experiences of other jurisdictions, the Committee recommends that this should be prescribed in the legislation and the process should not be overly complex.

8.110 The Committee notes that it is good practice for a clinical handover to occur from the Coordinating Practitioner to the Administering Practitioner.[575] The Committee notes that good practice would be for clinical handover to occur with the new Administering Practitioner after the role has been transferred. The Committee notes this will be a matter for the Coordinating Practitioner and the Administering Practitioner to determine. The Committee considers it is necessary for the transfer of roles to be reported to the Review Board.

Recommendation 39

The Committee recommends that the legislation should provide that:

- **a. The Administering Practitioner can transfer their role to another Authorised VAD Practitioner willing and able to act in the role for the person.**
- **b. The person and the Review Board (within two business days) should be notified of the transfer. The transfer should also be recorded in the person's medical record.**
- **c. The original Administering Practitioner must provide the new Administering Practitioner with the VAD Substance (if already in their possession).**

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[574] Australian Centre for Health Law Research, L. Willmott, B. P. White and Casey M Haining, *Review of the Voluntary Assisted Dying Act 2019 (WA): Research Report* (2024).

[575] Some examples of reasons an Administering Practitioner may be unable to administer the VAD Substance are set out in guidelines of other jurisdictions. See for example, Queensland VAD Review Board, *How to transfer practitioner roles* (2025), https://www.health.qld.gov.au/__data/assets/pdf_file/0023/1266512/fs-how-to-transfer-practitioner-roles-in-the-ims.pdf.

9 Steps after death

Overview

9.1 VAD legislation across Australia sets out the process that must be completed after the death of a person who was accessing VAD.

9.2 This Chapter examines this process, including responsibilities for death notification and to whom the death is reported.

Death notification

9.3 The death notification process for persons who die as a result of taking a VAD Substance, and for persons who die of other causes but were in the process of accessing VAD, is legislated across Australia. This is to ensure appropriate monitoring processes and safeguards are in place and adhered to.

9.4 There are two areas of death notification that have attracted debate, namely, whether the Coroner should be notified of all VAD deaths, and whether VAD should be listed as the cause of death on death certificates.

9.5 The Coroner is notified of a 'reportable death' for the purposes of the *Coroners Act 1993* (NT) if the death:

- appears to have been unexpected, unnatural or violent
- appears to have resulted, directly or indirectly from an accident or injury
- occurred during an anaesthetic or as a result of an anaesthetic and is not due to natural causes
- occurred when a person was held in, or immediately before death, was held in care or custody
- was caused or contributed to by injuries sustained while the person was held in custody
- of a person whose identity is unknown
- in certain other circumstances.[576]

9.6 The 2024 Expert Panel Report recommended that:

- The Contact Person and Coordinating Practitioner must notify the Review Board of all deaths of persons who have made a Formal Request for VAD;
- Notification to the Coroner should not be specifically required, but the Coroner should be notified about cases in which the certification and notification requirements of the legislation were not complied with, there is a suspicion that the person did not meet all eligibility requirements, or there were complications arising from administration of the VAD Substance; and

[576] NT Government, *Coroner and inquests* (2025), https://nt.gov.au/law/courts-and-tribunals/coroner-and-inquests/introduction.

- The cause of death of a person who has died by VAD shall be the underlying disease or illness that would have led to the person's death without VAD.[577]

9.7 The 2024 Expert Panel Report also proposed that annual or periodic reporting should be provided by the Review Board to the Coroner on the total number of VAD requests initiated, the proportion of those cases in which death occurred, and the proportion of those cases in which death occurred as a result of administration of the VAD Substance. [578] The Committee agrees with recommendation 18 of the 2024 in part.

Approaches in other jurisdictions

Notification of death

9.8 In other jurisdictions, including WA and the ACT, the Contact Person for the person accessing VAD must inform the Coordinating Practitioner if that person dies. In most jurisdictions, the Coordinating Practitioner must notify the Review Board.[579] The death must be reported whether it is death due to use of the VAD Substance, or due to another cause.[580]

9.9 Non-compliance with the legislative notification requirements is not uncommon in other States. For instance, where practitioners incorrectly complete a required form that is submitted to the Review Board or submit a form later than required.

9.10 The Committee notes that under the model proposed by the 2024 Expert Panel Report, 'complications' arising from the administration of the VAD Substance could include a wide range of potential outcomes, potentially resulting in the Coroner experiencing a high volume of notifications about minor instances of non-compliance.

9.11 Other jurisdictions, including Tasmania and Queensland, do not require all deaths due to VAD or deaths of persons accessing VAD to be reported to the Coroner.[581]

Death certificate

9.12 In other jurisdictions, for the purposes of a death certificate, the cause of death must not state that the person's death was a result of VAD.[582] As identified by the *Review of the Voluntary Assisted Dying Act 2019 (WA): Research Report*:

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[577] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), Recommendation 18 and p. 76.
[578] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024 (2024)*, p. 76.
[579] See for example *Voluntary Assisted Dying Act 2017* (Vic), s 67; *Voluntary Assisted Dying Act 2019* (WA), s 82; *Voluntary Assisted Dying Act 2021* (SA), s 84. In the ACT it is the responsibility of the Coordinating Practitioner (this could be an authorised medical or nurse practitioner) or the Administering Practitioner (could be the authorised medical or nurse practitioner or registered nurse) to notify the Board within 4 business days.; *Voluntary Assisted Dying Act 2024* (ACT), ss 79, 80.
[580] See for example *Voluntary Assisted Dying Act 2019* (WA), s 82; *Voluntary Assisted Dying Act 2024* (ACT), s 29.
[581] Tasmania s 93(2); *Voluntary Assisted Dying 2021* (Qld), s 171.
[582] See for example *Voluntary Assisted Dying Act 2019* (WA), s 82(6); *Voluntary Assisted Dying Act 2021* (QLD), s 81.

> The policy intention behind this restriction is to protect the person's privacy and reflect that the person died from their underlying illness.[583]

NSW requires cause of death as a result of VAD to be specified on the medical certificate but not the formal death certificate.[584]

Evidence before the Committee

Notification of death

9.13 Regarding the responsibility of the Contact Person to notify the Coordinating Practitioner when the person accessing VAD has died, the Committee heard that there may be some circumstances where cultural protocols need to be completed prior to this responsibility being fulfilled. A community leader from Maningrida stated:

> One time when I lost my dad and there was law. The police came and tried to take the body away. Straightaway, I said, 'Hey, hang on, that is my dad'. We need to have respect… get all the family to come with us. It has happened; a friend passed away at night. We need to know in the morning. Everybody there, there is Sorry Business before he removed to a mortuary. Got our family in there.[585]

9.14 Some submissions advocated for all VAD deaths to be referred to the Coroner.[586] However, most submissions that addressed this topic were supportive of the establishment of an independent Review Board as an effective mechanism for monitoring all VAD cases.[587]

9.15 Professor of End-of-Life Law and Regulation, Ben White and Professor of Law, Lindy Willmott, are of the view that oversight by the Coroner of VAD deaths is not a preferred approach, as deaths due to VAD are not a 'reportable death':

> We favour the establishment of a new retrospective review body dedicated to overseeing an assisted dying regime. We do note that responsibilities for reviewing individual deaths and also systemic issues around the operation of the legislation align well with the existing responsibilities of the Office of Coroner. Coroners also currently have duties and powers in relation to investigating certain types of deaths as well as making recommendations about systems improvement arising from the deaths investigated. However, oversight by the Coroner is not our favoured approach primarily because we do not consider deaths that result from a practice that is recognised as lawful should be in the same category as 'reportable deaths' currently investigated by Coroners (which sometimes includes connotations of these deaths being 'suspicious').
>
> By contrast, there are advantages of establishing a dedicated body (such as a review board) with sole responsibility for oversight of an assisted dying framework. This removes questions or associations of unlawful or inappropriate behaviour and the body's focus on assisted dying means it could be comprised of people with specific and relevant expertise in this area. The body's functions could include independent review of assisted dying cases (retrospectively), systems-level monitoring of the assisted dying regime (including the ability to make

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[583] L. Willmott, B. P. White and C. Haining, Queensland University of Technology, *Review of the Voluntary Assisted Dying Act 2019 (WA): Research Report* (2024), p. 69.
[584] *Voluntary Assisted Dying Act 2022* (NSW), s 87(6).
[585] Community representatives of Maningrida, Darwin, 25 August 2025.
[586] Submissions 149, 154, 334.
[587] See for example, Submissions 4, 21, 24, 33, 34, 53, 58, 69, 71, 91, 161

> recommendations for systemic reform), and appropriate data collection and reporting.[588]

9.16 Go Gentle Australia raised that notification to the Review Board ensures there is adequate oversight, with the referral powers ensuring breaches will be escalated to the appropriate authority:

> While there should be a comprehensive system of checks throughout the process, there needs to be a balance between the desire for transparency and oversight and the need to avoid unnecessary administrative burden for those delivering VAD and to ensure any oversight does not lead to delays in people accessing VAD. With its retrospective scrutiny, the Review Board has the power to refer breaches to the police, to AHPRA, to the coroner or to the medical board. This has the effect of reminding practitioners of their responsibilities under the law and of the high likelihood that any breaches will be detected and investigated.[589]

Death certificate

9.17 The Committee received mixed evidence on the topic of whether VAD or a person's underlying illness should be listed as the cause of death on the death certificate.[590] Various submissions raised that VAD should be noted as the cause of death for reasons of transparency and "honesty".[591]

9.18 The Committee heard there are important reasons to prioritise privacy in the after-death process of a person who has accessed VAD. The Australian Lawyers Alliance (ALA) were supportive of the death certificate listing the underling illness as cause of death to prevent that person's family from being disadvantaged due to their decision to choose VAD:

> The ALA contends that the Northern Territory should require that a person who dies through their participation in the Northern Territory's future Voluntary Assisted Dying scheme is taken to have died from the disease, illness or medical condition from which the person suffered, and which made them eligible for accessing Voluntary Assisted Dying. Legislation should require that this is reflected on that person's death certificate.
>
> This would acknowledge that Voluntary Assisted Dying is not suicide, as is explicitly noted in Voluntary Assisted Dying legislation in other jurisdictions in Australia, for the purposes of ensuring that a person and their family/support network are not disadvantaged through choosing Voluntary Assisted Dying. An example of this is the impact on a person's death insurance if their death through Voluntary Assisted Dying were to be classified as suicide.[592]

9.19 Other submitters had concerns about the effect of VAD on superannuation and life insurance.[593] The Committee notes that, in other jurisdictions, listing a person's illness as their cause of death of the death certificate (and not VAD) enables the person's life

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[588] L. Willmott and B. White, 'Assisted dying in Australia: a values-based model for reform' (2017), I. Freckelton and K. Petersen (eds) *Tensions and Trauma in Health Law, The Federation Press, pp. 479-510*.
[589] Submission 203.
[590] For inclusion of VAD as cause: Submissions 84, 321, 148, 18, 333, 334. Against inclusion of VAD as cause: Submissions 157, 181.
[591] Submissions 148, 84, 321.
[592] Submissions 157.
[593] Submissions 18, 157, 161, 224; Meeting with Tennant Creek Mob Aboriginal Corporation, Tennant Creek, 28 August 2025.

insurance claims and death benefits from superannuation to be unaffected.[594] The Clem Jones Group stated:

> The inclusion of this clear declaration in legislation not only represents a statement of fact, but also helps ensure VAD does not adversely impact or nullify life, health, or funeral insurance policies of a person whose death occurs as a result of the proper and legal administration of a VAD substance and that any such death is not deemed to be a "reportable death" needing coronial investigation.[595]

9.20 The Committee heard that listing a person's underlying illness on the death certificate could have positive implications for all involved in the VAD process. In remote communities, the Committee received evidence that healthcare workers may receive blame or payback if they take part in a VAD death.[596] Whilst no remote communities specifically referenced death certificates, the Committee notes that not including VAD on a death certificate could protect those involved in the VAD process.

9.21 The Committee notes there is evidence to suggest including VAD on death certificates may create social stigma for people bereaved by VAD.[597] Grief Australia stated:

> Families may experience complicated or disenfranchised grief, particularly where stigma, secrecy or cultural and spiritual conflict is present. Evidence shows that guilt, judgment and isolation are common among families bereaved through VAD. Children and adolescents bereaved by VAD deaths face additional challenges, yet there are few appropriate resources to support them.[598]

Committee comments

Notification of death

9.22 The Committee acknowledges that cultural protocols observed following a person's death can vary significantly across the Territory. Any timeframe prescribed for a Contact Person to notify the Coordinating Practitioner of a death should consider the need for any cultural practices to be heeded prior to the notification.

9.23 The Committee is of the view that VAD deaths do not meet the criteria for what should be considered a 'reportable death' for the purposes of the *Coroners Act 1993* (NT).

9.24 The Committee finds that visibility by the Review Board of deaths due to the VAD Substance or due to another cause ensures there is appropriate supervision and scrutiny of all aspects of a person's access to VAD services and that appropriate standards are being maintained.

9.25 Given these conclusions, in addition to the potential for a high volume of notifications about minor instances of non-compliance, the Committee recommends that only major or significant instances of non-compliance should be referred to the Coroner.

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[594] Go Gentle Australia, *Does voluntary assisted dying affect insurance payouts?* (2025), https://www.gogentleaustralia.org.au/does_voluntary_assisted_dying_affect_insurance_payouts.
[595] Submission 161.
[596] Meeting with Tennant Creek Mob Aboriginal Corporation, Tennant Creek, 28 August 2025.
[597] S. Philippkowski et al., 'Does voluntary assisted dying cause public stigma for the bereaved? A vignette-based experiment', *Palliative Support Care* 19(5) (2021), p. 560.
[598] Submission 384.

Refer to the section 'Review Board' of Chapter 12 for a discussion of the referral powers of the Review Board.

9.26 The drafting instructions reflect that the Review Board is best placed to manage and respond in cases of non-compliance or complications being experienced. The Review Board will be empowered to exercise its discretion to refer cases to the Coroner or other appropriate body in the event of major or significant instances of non-compliance or complications (see Chapter 12).

Death certificate

9.27 The Committee finds that the death certificate (or other cause of death certification) for a person must not state that that the person's death was as a result of VAD to:

- protect the person's privacy;
- mitigate against unintended consequences against a person who chooses VAD or family, friends and/or healthcare workers who assist a person to access VAD due to cultural practices or family beliefs;
- reflect that the person died from their underlying illness; and
- protect a person's family or support network from being disadvantaged based on the person's decision to choose VAD.

9.28 The Committee notes that general information and statistics will be available in the Review Board's annual reports to ensure there is openness and transparency of the VAD process. Refer to Chapter 12 for further detail on what information will be required to be included in annual reports.

Notification of death

Recommendation 40

The Committee recommends that the legislation should provide:

a. Within two business days of becoming aware of the person's death, the Contact Person must notify the Coordinating Practitioner about the death of the person where the person has:

i. died prior to Self-Administration; or

ii. self-administered the VAD Substance.

b. The Coordinating Practitioner and Administering Practitioner must notify the Review Board of the death of the person, whether they died following the administration of a VAD Substance or from another cause within two business days after becoming aware the person has died.

Death certificate

Recommendation 41

The Committee recommends that the legislation should provide that, if a medical practitioner who is required to give a cause of death certificate for a person knows

or reasonably believes that the person self-administered or was administered a VAD Substance, they must, within two business days after becoming aware of the person's death, notify the Review Board in the approved form of the person's death (unless they are the person's Coordinating Practitioner or Administering Practitioner so have already done so).

Recommendation 42

The Committee recommends that the legislation should provide that the death certificate or other cause of death certification for a person who died following administration of a VAD Substance must not state that the person's death was a result of, or caused by, VAD. Instead, the cause of death must be nominated as the underlying eligible terminal illness, disease or medical condition.

Notification to the Coroner

Recommendation 43

The Committee recommends that the legislation should provide that the death of a person who has accessed VAD is not a reportable death for the purposes of the *Coroners Act 1993* (NT).

10 Health practitioners' qualifications and training

Overview

10.1 VAD Practitioners fulfil three distinct and essential roles as a Coordinating Practitioner or Consulting Practitioner, assessing patient eligibility, and as an Administering Practitioner, in charge of administering VAD substances.[599]

10.2 This Chapter discusses the qualification, experience, expertise, and training requirements for health practitioners to become a Coordinating or Consulting Practitioner, or an Administering Practitioner.

Requirements for Coordinating and Consulting Practitioners

10.3 Across Australia, health practitioners must meet minimum qualification (period of registration) and training requirements to be able to undertake the role of Coordinating or Consulting Practitioner.

Qualification (prescribed period of registration) and expertise requirements

10.4 Medical practitioners acting in the Coordinating or Consulting Practitioner roles require a minimum qualification (period of registration). This requirement balances supporting equity and access to VAD while ensuring safeguards (such as appropriate qualifications) are in place.

10.5 The 2024 Expert Panel Report recommended that VAD assessments must be conducted by appropriately trained medical practitioners only. The Panel concluded that medical practitioners should hold at least five years registration, or one year of specialist registration to be eligible to become VAD practitioners.

10.6 The Panel found that overly prescriptive requirements for specialist registration or expertise in end-of-life care would severely hinder access due to the limited number of specialist medical practitioners in the NT and the requirement for face-to-face assessments.[600]

10.7 The Committee supports Recommendation 3 of the 2024 Expert Panel Report.

Training requirements

10.8 Mandating medical practitioners complete approved training before providing VAD services establishes knowledge standards and ensures there is consistent decision-making in accordance with the NT VAD legislation.

10.9 The 2024 Expert Panel Report recommended that VAD practitioners must undergo mandatory training. They noted that the training requirements for NT VAD practitioners would be unique. The Panel heard that training should go beyond

[599] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 62.
[600] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), pp. 33-36.

compliance and legislative function, to include topics such as clinical skills, communication skills and cultural safety. The 2024 Expert Panel Report noted barriers to completing mandatory training including the unpaid nature of the training and absence of recognition for Continuing Medical Education (CME), also known as Continuing Professional Development (CDP), credits.[601] CME is "any way by which doctors learn after the formal completion of their training" with the primary purpose being "to keep professionals up-to-date with the latest knowledge in their profession and to enable competent practice for the benefit of patient care".[602]

10.10 The 2024 Expert Panel Report noted that barriers may discourage health practitioners from pursuing VAD training, potentially resulting in only a small number of health practitioners being VAD trained and available. This increases the risk of burnout. Strategies to incentivise training include making the VAD training "eligible for CME points, providing dedicated non-clinical training time, and securing appropriate funding".[603]

Approaches in other jurisdictions

10.11 The minimum qualification and experience requirements for Coordinating and Consulting Practitioners vary between the jurisdictions as shown in Table 4 below.

10.12 In all jurisdictions, Coordinating and Consulting Practitioners must be experienced medical practitioners, except in the ACT where experienced nurse practitioners are also permitted to undertake one of the VAD assessments.

10.13 The ACT's approach to also enable nurse practitioners to undertake VAD assessments "stemmed from a concern about the small healthcare workforce in the ACT and the need to ensure access to VAD for patients in practice".[604] Research has found that "nurses have the qualifications and skill set for end-of-life care work and already practise in primary and aged care sectors" and may be "more willing to participate in VAD than medical practitioners".[605]

10.14 All jurisdictions require the Coordinating and Consulting Practitioners to be independent from the person accessing VAD (i.e. not a family member or a beneficiary) to ensure there is no conflict of interest or potential for personal gain.

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[601] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), pp. 37-38.
[602] H. M. H. Alshehri, 'Primary health care professionals' opinions regarding continuing medical education: A cross sectional study', *Medicine (Baltimore)* 13;103(50) (2023).
[603] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 38.
[604] H. M. H. Alshehri, 'Primary health care professionals' opinions regarding continuing medical education: A cross sectional study', *Medicine (Baltimore)* 13;103(50) (2024).
[605] J Hewitt, L. Grealish and A. Bonner, 'Voluntary assisted dying in Australia and New Zealand: Exploring the potential for nurse practitioners to assess eligibility', *Collegian* 30(1) (2023).

Table 4: Qualification Requirements for VAD Practitioners[606]

Provision	VIC	WA	TAS	SA	QLD	NSW	ACT
Medical practitioner must be VAD trained	✓	✓	✓	✓	✓	✓	✓ Nurse practitioner may undertake one VAD assessment
Medical practitioner cannot be a family member	✓	✓	✓	✓	✓	✓	✓
Medical practitioner cannot be a beneficiary	✓	✓	✓	✓	✓	✓	✓
Specialist qualifications or specified years with general qualification	✓ One medical practitioner must have 'relevant experience' in eligible condition; interpreted in Victoria to mean one medical practitioner must be a 'specialist' in the eligible condition	✓ Both medical practitioners to have 'relevant experience' in eligible condition	✓ One medical practitioner to have 'relevant experience' in eligible condition	✓	✓	✓	✓
Years of practice	5	10 for general registration; 1 for specialist registration	5	5	5 for general registration; 1 for specialist registration	10 for general registration	5 for general registration; 1 for specialist registration

Evidence before the Committee

10.15 The Committee received a large amount of evidence regarding the qualification and training requirements for Coordinating and Consulting Practitioners.

Qualification (prescribed period of registration) and expertise requirements

10.16 There was support for the requirement for medical practitioners to have five years of general registration and/or one year of specialist registration.[607]

10.17 Some stakeholders outlined their opposition to introducing a requirement that one of the Coordinating or Consulting Practitioners is a disease-specific specialist, stating that this would not be a feasible option in the NT and would result in inequitable

[606] Submission 136.
[607] Submissions 55, 71, 157, 368.

access.[608] For example, at a community drop-in consultation in Tennant Creek, community advocate, Alba Brockie, stated:

> And finding two doctors when you cannot get one. I needed to get old ladies who missed appointments yesterday into the GP. We cannot do it until next week. To find somebody, and then to find someone else in five days or somebody who has that exact training, there is probably only one doctor specialising in this particular thing and they may not even live in the Northern Territory, and then you have to find a second.[609]

10.18 The Australian Lawyers Alliance also noted that VAD Practitioner requirements should not be too restrictive to ensure there is equity of access for people living outside of urban centres:

> While eligibility requirements for health professionals may be to ensure they have the necessary skill and expertise to participate in a Voluntary Assisted Dying scheme, in practice requirements that are too specific or narrow jeopardise equitable access to the scheme, especially for persons living in smaller jurisdictions and/or regional, rural and remote communities where access to a range of doctors with specific qualifications can be very limited.[610]

10.19 AMA NT stated that other requirements of the VAD process ensure safe and high-quality standards are maintained:

> …assessing practitioners… must have completed mandatory, accredited, NT-specific VAD training. Crucially, the legislation must then mandate a formal consultation pathway. As part of the first assessment, the coordinating practitioner must be legally required to obtain and document confirmation of the patient's diagnosis and prognosis from a relevant medical specialist. This provides the necessary expert oversight without becoming a physical gatekeeper to the process. This hybrid model balances the need for robust clinical governance with the practical realities of healthcare delivery in the Territory.[611]

10.20 There was a significant amount of support for enabling registered nurses to be Coordinating and Consulting Practitioners.[612] Go Gentle Australia noted the rationale provided in the ACT for enabling nurse practitioners to be Coordinating or Consulting Practitioners was that:

> …nurse practitioners are experienced, highly qualified nurses and enabling them to perform some of the VAD procedures, alongside doctors, will ease workload pressures in the ACT's already small workforce and support sustainability of VAD services.[613]

10.21 Go Gentle Australia also outlined that a broader role for nurses in the VAD process was raised as a high priority by attendees of the 2023 trans-Tasman VAD Conference.[614]

10.22 Dying with Dignity Victoria raised that there is a potential for burnout if only a small number of medical practitioners can become VAD Practitioners:

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[608] Submissions 368, 319, 321; Community drop-in session, Tennant Creek, 27 August 2025.
[609] Community drop-in session, Tennant Creek, 27 August 2025.
[610] Submission 157.
[611] Submission 368.
[612] Submissions 55, 101, 108, 125, 157, 319, 378.
[613] Submission 203.
[614] Submission 203.

> There is a need to strike a balance between ensuring practitioners are appropriately qualified while also ensuring that practitioners are not unnecessarily deterred from participation. Victoria's experience suggests that a small number of practitioners will provide most VAD services, which risks burnout of those practitioners. We support establishing an administering practitioner role that nurses can also fulfill.[615]

10.23 AMA NT acknowledged the significant role of nurses in the delivery of VAD but did not support nurse practitioners being able to fulfil the Coordinating or Consulting Practitioner roles:

> The consultations to decide eligibility and suitability should be in the hands of physicians, which is consistent with medical care delivery across Australia.[616]

VAD Training requirements

10.24 Voluntary Assisted Dying South Australia stated its opposition to the requirement for VAD Practitioners to complete VAD-specific mandatory training:

> A major disadvantage of the requirement for doctors (and in some states nurse practitioners) to be VAD trained is that it limits access to VAD compared with those overseas jurisdictions where doctors and nurse practitioners are not required to complete additional VAD specific training. In South Australia, for example, at March 31, 2025, after 26 months of implementation, there were 82 VAD trained doctors. There are over 8000 registered medical practitioners in SA. This means that only 1% of doctors in SA are available to assess eligibility for VAD. A person requesting VAD is unlikely to know a VAD trained doctor; their treating doctor is unlikely to be VAD trained. Our experience in SA is that the requirement for doctors (and nurse practitioners in some jurisdictions) to have specific VAD training creates a barrier to access to VAD without providing a safeguard or protection for vulnerable people. Doctors rely on their clinical training and experience to assess VAD eligibility, not their VAD training.[617]

10.25 Other evidence presented to the Committee supported VAD-specific mandatory training.[618] Stakeholders raised that topics to be covered should include compliance and legal requirements, but that the training should go beyond these basic topics to include training on culturally appropriate or safe practice, ethics, voluntariness, general communication training, and communication training specific to people with complex communication needs.[619]

10.26 The Committee heard from AMA NT that NT-specific training should be developed with input from palliative care physicians and nurses, lawyers and pharmacists:

> A training package would have to be developed for an NT standalone system, if only to make sure we address specific Northern Territory concerns on top of the education and training that would be needed to deliver a VAD service, and the mechanics of that. That training package would need the input, guidance and design of palliative care physicians. That would also include palliative care nursing

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[615] Submission 125.
[616] Australian Medical Association NT, Public Hearing, Darwin, 5 August 2025.
[617] Submission 136.
[618] Submissions 71, 91, 108, 179.
[619] Submissions 21, 179, 182, Australian Medical Association NT, Public Hearing, Darwin, 5 August 2025; Meeting with Pulkapulkka Kari Flexible Aged Care, Tennant Creek, 27 August 2025; Community drop-in session, Tennant Creek, 27 August 2025; Meeting with staff member at Tennant Creek Hospital, Tennant Creek, 28 August 2025.

> staff, lawyers and legal advice in this space, and pharmacists who have been involved with that prior to this. It is quite a broad and multidisciplinary training program.[620]

10.27 Alice Springs Hospital Heads of Department raised that there should be training provided to medical practitioners and clinicians who will need to respond to requests for VAD or discuss the topic with Aboriginal patients:

> Inclusion of topics related to requests for VAD and how to best respond to these should be included in general communication training for medical practitioners in future… Completion of cultural training should be a pre-requisite for clinicians having discussions about VAD with Aboriginal patients.[621]

Exclusions

10.28 The Committee did not receive any evidence about exclusion criteria for Coordinating and Consulting Practitioners.

Committee comments

Qualification (prescribed period of registration) and expertise requirements

10.29 The Committee finds that medical practitioners acting in the Coordinating or Consulting Practitioner roles should have a minimum period of registration. This requirement balances supporting equity and access to VAD while ensuring safeguards, such as appropriate qualifications, are in place.

Training requirements

10.30 Requiring VAD Practitioners to undertake approved mandatory training before providing VAD services is a safeguard that ensures a required standard of knowledge and consistent decision-making in accordance with the NT VAD legislation. The training should include content about legislative processes, clinical skills, ethics, communication skills and supporting cultural beliefs and practices surrounding end-of-life care for Aboriginal and Torres Strait Islander People.

10.31 Reflecting the approach in other jurisdictions, the CEO of the Department of Health should have authority to approve the required content of the mandatory training.[622] Enabling additional requirements for practitioners to be imposed by the CEO of the Department of Health ensures the CEO can make policy guidelines to cover training requirements. This means that there will be flexibility and adaptability for future requirements. Barriers to completing mandatory training, as identified by the 2024 Expert Panel report, should be addressed during the planning and implementation phase.

The Committee is of the view that training is not required to accept a First Request. It is, however, required to assess a person's eligibility.

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[620] Australian Medical Association NT, Public Hearing, Darwin, 5 August 2025.
[621] Submission 179.
[622] *Voluntary Assisted Dying Act 2019* (WA), s 160, *Voluntary Assisted Dying Act 2021* (QLD), s 165, *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (TAS), s 117.

Exclusions

10.32 The Committee recommends the Australian model of VAD be followed in relation to circumstances where a medical practitioner would be excluded from performing the role of Coordinating or Consulting Practitioner.

Qualification (prescribed period of registration) and expertise requirements

Recommendation 44

The Committee recommends that the legislation should provide that Coordinating and Consulting Practitioners must:

a. Be qualified medical practitioners with at least:

i. five years general registration; or

ii. one year of specialist registration.

b. Meet the approved medical practitioner requirements as determined by the CEO.

Training requirements

Recommendation 45

The Committee recommends that the legislation should provide that:

a. Coordinating and Consulting Practitioners must have completed the mandatory training before providing VAD services.

b. The content of the mandatory training must be approved by the CEO.

Exclusions

Recommendation 46

The Committee recommends that the legislation should provide that Coordinating or Consulting Practitioners may not be:

a. A Family Member of the person requesting access to VAD.

b. A beneficiary under the will of the person accessing VAD and will not otherwise benefit financially from the person's death.

Administering Practitioners

10.33 An Administering Practitioner is a health practitioner who assists a person to administer the VAD Substance. The role is only required if a person selects Practitioner Administration.

10.34 The 2024 Expert Panel Report did not make any specific recommendations about the qualifications required for an Administering Practitioner. However, it generally recommended that VAD Practitioners should undergo mandatory training and hold appropriate qualifications.

Approaches in other jurisdictions

10.35 In other jurisdictions there are varying requirements for who can be an Administering Practitioner. All jurisdictions enable medical practitioners to act as an Administering Practitioner. Under the ROTI Act, only a medical practitioner could assist a patient to end their own life.[623]

10.36 Nurse practitioners are permitted to be Administering Practitioners in all Australian jurisdictions, [624] except Victoria and SA.[625] In addition, some jurisdictions allow registered nurses to administer the VAD Substance, provided they meet certain requirements (e.g. have two to five years of nursing experience).[626]

10.37 Enabling a nurse to be an Administering Practitioner gives more flexibility in the process, alleviates the potential strain on Coordinating Practitioners and provides an additional check and balance safeguard by making the roles distinct and separate.[627]

10.38 In Queensland, registered nurses account for 45 per cent of Administering Practitioners and nurse practitioners account for an additional six per cent, demonstrating the significant roles that nurses play in the state.[628] In WA, the VAD Board has noted a steady increase in nurse practitioner involvement in the VAD process.[629]

10.39 Other jurisdictions have requirements that a person acting as an Administering Practitioner should not be a beneficiary under the will of the person accessing VAD or otherwise financially benefit from the person accessing VAD.[630]

Evidence before the Committee

10.40 There was broad agreement amongst stakeholders that medical practitioners were appropriately placed to be Administering Practitioners, with many noting that this role would likely be filled by the Coordinating Practitioner.

10.41 Many submitters discussed the advantages of involving nurse practitioners and registered nurses as Administering Practitioners.[631] Stakeholders noted that involving these roles would increase the pool of available health practitioners available to assist with VAD. Professor Ben White and Professor Lindy Willmott stated:

> We support nurses and nurse practitioners having a broader range of roles in the VAD process. We consider this is an important improvement to the Victorian model (which does not permit nurse practitioners or nurses having a role in the VAD request and assessment process) as it addresses potential barriers to access for patients. It does this by increasing the 'pool' of providers able to assist a patient

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[623] *Rights of the Terminally Ill Act 1995* (NT), Part 2.
[624] *Voluntary Assisted Dying Act 2022* (NSW), s 83(a)(ii); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas), s 63.
[625] *Voluntary Assisted Dying Act 2017* (Vic), s 64.
[626] *Voluntary Assisted Dying Act 2022 (NSW),* s 83(a)(iii); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas), s 63; *Voluntary Assisted Dying Act 2019* (WA), s 54.
[627] B. White et al., 'Models of care for voluntary assisted dying: a qualitative study of Queensland's approach in its first year of operation', *Australian Health Review* (2024).
[628] Queensland VAD Review Board, *Annual Report 2023-24* (2024).
[629] WA VAD Review Board, *Annual Report 2023-24* (2024).
[630] For example, *Voluntary Assisted Dying Act 2022 (NSW),* s 83(d).
[631] Submission 46, 55, 71, 108, 125, 136, 336.

> to access VAD, which may be important in light of the NT's specific health workforce capabilities.[632]

10.42 Other stakeholders noted nurses may be best placed to help with administration of the VAD Substance, noting their skillset. End-of-Life Choice Society New Zealand stated:

> Nurse practitioners and nurses are more readily available to the person and family than the doctor is, especially in care home facilities, and are especially skilful in understanding family dynamics which is a safeguard against coercion one way or the other.[633]

10.43 Similarly, Dr John Zorbas, President of AMA NT, noted:

> …we recognise that there are significant roles for nurses and nurse practitioners in the delivery of VAD. A service would not be able to be delivered without their input… Currently in medical practice, generally, nurses would be administering medication and substances on a daily basis, so it would fit with routine practice that it would be available to nurses and nurse practitioners.[634]

10.44 Some stakeholders suggested minimum registration for nurse practitioners and registered nurses, for example, one year of registration.[635] By contrast, others did not recommend prescribing a minimum time. NT resident, Margaret Warburton, stated:

> There should be no requirement for them to have had a minimum level of experience because doing so would no doubt restrict the number of persons able to perform this service. Apart from which 'experience' is too vague. People may have had a range of experience outside the health system that would admirably equip them to assist patients through the process.[636]

10.45 Some stakeholders discussed training requirements for Administering Practitioners. In general, these comments mirrored those discussed in the section on Coordinating and Consulting Practitioners, with training including Continuing Professional Development accredited modules.[637] A limited number of stakeholders recommended that no training should be required as this could create barriers to access.[638] In remote communities, the Committee heard that remote nurses would like the opportunity to receive VAD training.[639] However, the Committee also heard there was a shortage of nurses in communities and this could impact on their capacity to aid with VAD (if a community-based model is adopted).[640]

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[632] Submission 5.
[633] Submission 134.
[634] Australian Medical Association NT, Public Hearing, Darwin, 5 August 2025.
[635] Submission 55.
[636] Submission 108.
[637] Continuing Professional Development is also known as Continuing Medical Education (CME).
[638] Submission 136.
[639] Meeting with Borroloola Local Authority, Borroloola, 7 August 2025.
[640] Meeting with Borroloola Local Authority, Borroloola, 7 August 2025.

Figure 16: Community engagement in Numbulwar

Committee comments

10.46 The Committee notes the realities of workforce shortages must be contended with in delivering VAD in the NT. In this regard, the Committee considers it appropriate to ensure a wide range of appropriately qualified and trained health practitioners can help deliver VAD. The Committee notes that expanding the categories of health practitioners that can act in the Administering Practitioner's role will enhance access to VAD and alleviate the potential strain on participating medical practitioners. The Committee notes this approach is consistent with the majority of other Australian jurisdictions.

10.47 The Committee considers it appropriate that, where the Administering Practitioner is a different person from the Coordinating Practitioner, the Administering Practitioner will have obligations to ensure they are satisfied that all preceding steps or requirements in the process have been met.

10.48 The Committee concurs with the 2024 Panel Report and considers that administering Practitioners should undertake mandatory training before participating as an Administering Practitioner. The Committee considers that the training requirements for Administering Practitioners should be the same as for Coordinating and Consulting Practitioners.

10.49 The Committee also considers that the requirements for Administering Practitioners should be consistent with other jurisdictions, including specifying that they should not be a beneficiary under the will of the person accessing VAD or otherwise financially benefit from the person accessing VAD.

Qualification (prescribed period of registration) and expertise requirements

Recommendation 47

The Committee recommends that the legislation should provide that:

a. Administering Practitioners must be a qualified medical practitioner, a nurse practitioner, a registered nurse who has practised in the nursing profession for more than 5 years.

b. Administering Practitioners must meet the approved practitioner requirements as determined by the CEO.

Training requirements

Recommendation 48

The Committee recommends that the legislation should require Administering Practitioners to have completed the standard mandatory training before being able to undertake the role of Administering Practitioner.

Exclusions

Recommendation 49

The Committee recommends that the legislation should provide that the Administering Practitioner may not be:

a. A Family Member of the person requesting access to VAD.

b. A beneficiary under the will of the person accessing VAD and will not otherwise benefit financially from the person's death.

11 Non-participation by healthcare workers and entities

Overview

11.1 This chapter discusses the rights and responsibilities of individual healthcare workers and institutions where they conscientiously object to VAD.

Conscientious objection by individual practitioners

11.2 Conscientious objection occurs when a health practitioner, as a result of a conflict with their own personal beliefs or values, refuses to provide or participate in a legal, legitimate treatment or procedure which would be deemed medically appropriate in the circumstances under professional standards. It is based on sincerely-held beliefs and moral concerns, not self-interest or discrimination.[641]

11.3 It is important to note that for Aboriginal people, including Aboriginal Health Practitioners and those working in the health system, there is deep cultural and social significance associated with the process of dying, death and grieving. In many former missionary communities, this is also overlaid with deeply held faith-based convictions. The context in which conscientious objection clauses are drafted for NT VAD legislation therefore needs to respect and recognise this.

11.4 The 2024 Expert Panel Report proposed that every request by a patient for VAD be referred to a centralised VAD service. Those with a conscientious objection would be obliged to pass on information to a patient about the centralised VAD service as it would not be an undue interference with their conscientious objection.[642] Although a centralised VAD model would provide a safeguard, the Committee queried in its Consultation Paper whether health practitioners who conscientiously object or who choose to not participate in the VAD process should be required to declare their objection or non-participation to a person who is, or may be interested in, accessing VAD.[643]

11.5 The Expert Panel also noted that while health practitioners should not be required to participate in VAD, there is a community expectation that objecting should not impede access and should support patients to connect with another health practitioner or health service who can assist. The Expert Panel did not specifically consider which group of healthcare workers these rights and obligations should apply to.

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[641] Australian Medical Association, *Conscientious Objection – 2019* (2019), https://www.ama.com.au/position-statement/conscientious-objection-2019; Queensland Government, *Conscientious objection* (2023), https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/voluntary-assisted-dying/information-for-healthcare-workers/conscientious-objection.

[642] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 40.

[643] Legal and Constitutional Affairs Committee, *Inquiry into Voluntary Assisted Dying in the Northern Territory – Consultation Paper* (2025).

11.6 The Committee adopts Recommendation 4 of the 2024 Panel, as it relates to the participation of individual health practitioners.

Approaches in other jurisdictions

11.7 The right of health practitioners to conscientiously object to providing or being involved with VAD services is specifically recognised in all Australian jurisdictions. In some of those jurisdictions, health practitioners are required to either: refer the person to another health practitioner or service that is likely to be able to provide VAD; or provide specified information to the person (generally the contact details of the VAD Care Navigator service).

11.8 For example, medical practitioners must notify the patient of their conscientious objection immediately in Queensland and NSW.[644] In Victoria and SA, a practitioner has seven days to respond.[645] In the ACT a practitioner must provide details of a navigator service.[646] In Queensland a practitioner must refer the person to another health practitioner who can assist or the care navigator.[647]

11.9 Within the Australian model of VAD, provisions relating to conscientious objection generally only apply to registered health practitioners. However, recognising the important role that speech pathologists (who are self-regulating health professionals) may play in the VAD process, the Queensland legislation also regulates the non-participation of speech pathologists.[648]

Evidence before the Committee

11.10 The Committee received multiple submissions that argued conscientious objectors should not be required to participate in the VAD process, nor refer a patient on to someone who can assist with a VAD service.

11.11 Individual, Kristan Slack stated:

> I strongly reject any move expecting a GP or medical professional who objects to VAD being obliged to refer a person on to a service which does not object. This does not genuinely respect conscientious objection.[649]

11.12 Individual, Dr Ray Ingamells noted:

> In the NT VAD reports, I note that a health professional who is a conscientious objector will be legally required to inform patients of VAD services that would be available. This means that I cannot exercise my right to be a conscientious objector and simply refuse a patient's request for VAD, but I will be required to provide information that helps them take the next step towards taking their own life. This would make me part of the process for providing VAD for them.[650]

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[644] *Voluntary Assisted Dying Act 2021* (Qld), s 16(4); *Voluntary Assisted Dying Act 2022* (NSW), s 21(3). In the *Voluntary Assisted Dying Act 2019* (WA), a practitioner has a responsibility to notify the patient immediately due to conscientious objection occurs when the practitioner refuses a First Request (s.20(5)) or refuses a Consultation Referral (s.31(5)).
[645] *Voluntary Assisted Dying Act* 2017 (Vic), s 17; *Voluntary Assisted Dying Act 2021* (SA), s 31.
[646] *Voluntary Assisted Dying Act 2024* (ACT), s 100.
[647] *Voluntary Assisted Dying Act 2021* (Qld) s 16(4).
[648] *Voluntary Assisted Dying Act 2021* (NSW), s 84(2).
[649] Submission 18.
[650] Submission 76.

11.13 The Catholic Diocese of Darwin argued:

> If euthanasia and assisted suicide are legalised, healthcare professionals and faith-based institutions including hospitals and aged care, must retain the right to refuse to participate in the practice of giving a patient lethal drugs. Doctors must have the right to refuse to refer to someone to another doctor who would take such unethical action, without penalty…[651]

11.14 The Committee also received evidence supportive of individual practitioners' right to conscientiously object, yet maintaining an obligation to refer a patient on so as not to impede the patient's right to access the service.

11.15 Individual, Geoffrey Williams stated:

> Opponents of VAD insist on their right to conscientiously object to being involved with VAD, but they vehemently deny other people the right to choose VAD without obstruction. This blatant display of double standards is staggering.[652]

11.16 Individual, Christine Mansfield noted:

> I support the implementation of rigorous and legally sound safeguards to protect all involved—patients, families, and healthcare providers. While I am not an expert in the legal or medical details of these mechanisms, I believe the Northern Territory can draw on best practices from other states and overseas. Safeguards should include… The right for healthcare professionals to conscientiously object.[653]

11.17 AMA NT argued:

> The AMA Position Statement strongly supports the right of all doctors to conscientiously object to participation in VAD. This is a fundamental ethical protection for medical professionals. However, this right is not absolute; it is balanced by the professional duty to the patient. A doctor who conscientiously objects must inform the patient of their objection in a timely manner and must not obstruct the patient's access to care. They have an obligation to ensure the patient has sufficient information to enable them to seek that care from another practitioner or service. The proposed centralised VAD service model provides an elegant and practical solution to this ethical challenge…[654]

11.18 The Committee notes that the Pharmaceutical Society of Australia's (PSA) Code of Ethics already contains guidance on conscientious objection. According to the Code, pharmacists who do not wish to participate in matters where they have an objection are required to ensure patients have information on how to access a pharmacist that can provide the support the patient requires. The PSA is of the view that clinicians who opt in or out of providing and supporting people's access to VAD should not be discriminated against and that health services should not assume or expect staff, including clinicians, to adhere to the same beliefs as the health service.[655] The PSA's position on institutional objection is discussed later in this chapter.

11.19 Similarly, the Pharmacy Guild of Australia Northern Territory Branch (PGNT) advised that:

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[651] Submission 97.
[652] Submission 68.
[653] Submission 33.
[654] Submission 368.
[655] Submission 402.

> The legalisation of VAD may present an ethical or social challenge for some community pharmacists who may have an objection to the supply of medicines used to end the life of a terminally ill patient. The PGNT respects and supports the rights of all health practitioners, including pharmacists, who conscientiously object to VAD to refuse to participate in discussions of, requests for, or processes of, a VAD service. We believe it is appropriate for the health practitioner to inform the person when first approached and to be prepared to refer appropriately.[656]

11.20 Allied health professionals such as speech pathologists are not registered as health practitioners. Hence the protections that extend to health practitioners under VAD legislation, including the right to conscientiously object and, in some jurisdictions, obligation to refer on, are not articulated. The Queensland VAD legislation is an exception in this regard.

11.21 The Committee carefully considered the submission it received from Speech Pathology Australia (SPA).[657] It sets out the important role that speech pathologists have in VAD. This includes assisting people experiencing communication and swallowing difficulties, for example people with progressive neurological conditions such as Motor Neuron Disease, or cancers of the head, neck and brain, to access VAD. SPA made several recommendations to the Committee, including the need for the VAD legislation to explicitly recognise 'Certified Practising Speech Pathologists' as having the same legal protections including immunity from criminal and civil liability and the right to conscientiously object to participation in the VAD process.

11.22 In the course of its Inquiry, the Committee also learnt of the critical role of other healthcare workers in the delivery of NT healthcare, including social workers, occupational therapists, ALOs and interpreters. The Committee heard in some instances that these workers would like the right to conscientiously object to participation in the VAD process. For example, in Alice Springs, the Committee heard from an ALO and interpreter who would not want to assist with VAD.[658]

11.23 NT Health advised the Committee that the challenge with conscientious objection could be largely taken care of by having a standalone VAD model.[659]

Committee comments

11.24 The Committee supports the voluntariness of a VAD framework and considers that this extends to healthcare workers involved in the VAD process. The Committee considers that healthcare workers who conscientiously object to VAD should be able to choose not to participate.

11.25 However, the Committee notes conscientious objection should not impede on accessibility. The right to conscientiously object should not impede or hinder the ability of people to access VAD. In this regard, the Committee believes that health practitioners who choose not to participate in VAD on the basis of a conscientious objection should be required to give the person information about another health

[656] Submission 167.
[657] Submission 182.
[658] Meeting with Alice Springs Hospital Aboriginal Engagement and Strategy Unit, Alice Springs, 21 August 2025.
[659] NT Health, Public Hearing, Darwin, 5 August 2025.

practitioner or health service who can assist or provide the contact details of the VAD navigator service.

11.26 The Committee proposes that the legislation should regulate registered health practitioners, speech pathologists, social workers, occupational therapists, ALOs and interpreters involved in the delivery of healthcare.

Recommendation 50

The Committee recommends that the legislation should provide that a 'relevant person involved in providing or supporting the provision of health or care services' who conscientiously objects to VAD may refuse to participate or be involved in VAD.

Recommendation 51

The Committee recommends that the legislation should provide that a 'relevant person involved in providing or supporting the provision of health or care services' who conscientiously objects to VAD should have a right to refuse to do any of the following:

a. Provide information about VAD;

b. Participate in the request and assessment process;

c. Participate in an Administration Decision;

d. Prescribe, supply or administer a VAD Substance; and

e. Be present at the time of administration of a VAD Substance.

Recommendation 52

The Committee recommends that the legislation should provide that a 'relevant person involved in providing or supporting the provision of health or care services' who, because of a conscientious objection, refuses to participate in any of the steps noted in Recommendation 51 for a person seeking information or assistance in relation to VAD, must:

a. Inform the person that another health practitioner or health service may be able to assist the person; and

b. Give the person:

i. information about a health practitioner or health service that is likely to be able to assist the person; or

ii. the contact details of the official VAD navigator service.

Recommendation 53

The Committee recommends that the legislation should provide that, despite Recommendation 52, medical practitioners must comply with the obligations in relation to a First Request (see Recommendations 16(b) and 16(c)).

Participation by health or care entities

11.27 Institutional objections "are forms of conscientious objection that operate at an organisational level".[660] Institutional objections in relation to VAD are often faith-based.[661]

11.28 How the rights and obligations of these institutions are conceptualised is a contested topic.[662] There is debate about whether an institution can maintain an objection on a "moral or ethical position based on conscience" as an institution "cannot experience guilt or suffer moral injury from acting against its conscience". On the other hand, some argue that "institutions may have a distinct mission and moral identity" which could be considered "analogous to an individual's conscience". [663]

11.29 It has been noted that institutional objection may create a wider barrier of access for people than in the case of individual conscientious objection, and that there may be more diverse reasons why institutions want to object.[664]

11.30 In 2024, the Expert Panel proposed that in the NT, residential facilities should not be able to hinder permanent residents of the facility from accessing VAD on site, and should allow requests, assessments and administration of VAD for residents who wish to undergo VAD. This was to respect residents' dignity, support delivery of optimal person-centred care, and not impede a person's right to access lawful treatments.[665]

11.31 The Committee examined 2023-24 interstate data on the most common settings for people taking the VAD Substance. It shows that the preferred setting is typically a private residence – either the patient's home or another residence, followed by hospital.

11.32 The Expert Panel did not identify a policy position on the issues of access to VAD for people in:

- residential facilities who are not permanent residents; or
- health or care entities that are not residential facilities, such as hospitals.

11.33 The Committee considers this to be a major omission.

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[660] I. Kerridge et al., 'Conscientious objection and institutional objection to voluntary assistance in dying: an ethico-legal critique' (2023), *Journal of Law and Medicine*, 30(4).

[661] B. P. White et al., 'The impact on patients of objections by institutions to assisted dying: a qualitative study of family caregivers' perceptions' (2023), *BMC Med Ethics*, 24(1):22.

[662] B. P. White et al., 'The impact on patients of objections by institutions to assisted dying: a qualitative study of family caregivers' perceptions' (2023), *BMC Med Ethics*, 24(1):22; I. Kerridge et al, 'Conscientious objection and institutional objection to voluntary assistance in dying: an ethico-legal critique' (2023), *Journal of Law and Medicine*, 30(4).

[663] B. P. White et al., 'The impact on patients of objections by institutions to assisted dying: a qualitative study of family caregivers' perceptions' (2023), *BMC Med Ethics*, 24(1):22.

[664] B. P. White et al., 'The impact on patients of objections by institutions to assisted dying: a qualitative study of family caregivers' perceptions' (2023), *BMC Med Ethics*, 24(1):22.

[665] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), pp. 40-41.

Approaches in other jurisdictions

11.34 Provisions on institutional object vary across jurisdictions. The Victorian, WA and Tasmanian legislation is silent on the issue of institutional objection and the matter has been left to be regulated in policy.[666]

11.35 SA, Queensland, NSW and the ACT all provide for conscientious objection by institutions.[667] In SA, objecting institutions must advertise and inform patients about their objection. They must also inform patients about arrangements they can reasonably take to transfer patients to other institutions to access VAD.[668] Queensland and NSW have different requirements for patients in institutions that are permanent residents (i.e., the facility is their home) or non-permanent residents. There are general limits on institutions, including:

- advertising the institution does not provide VAD services;[669]
- not hindering patients from seeking information about VAD and allowing VAD practitioners reasonable access to patients to provide information;[670]
- permitting VAD practitioners and witnesses to enter the institution to engage in VAD activities;[671] and
- taking reasonable steps to transfer the patient if access is not possible.[672]

11.36 Additional requirements apply for permanent residents of institutions, including the right to reasonable access to VAD services on site. Transfer is only considered if a VAD practitioner cannot come on site,[673] and transfer cannot occur if it would adversely affect a patient and access must be allowed onsite. In considering whether it is reasonable to transfer a patient, a VAD practitioner must consider a range of factors, including whether it would cause harm or suffering, impede access, or cause financial loss.[674]

11.37 In the ACT, there is no distinction between residential and non-residential requirements. Similar requirements apply as NSW and Queensland. In addition, all institutions must have a policy on how they will comply with these requirements.[675]

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[666] See for example, Tasmanian Department of Health, *Voluntary Assisted Dying in Tasmania – Planning for Voluntary Assisted Dying – Health Service Establishments – Residential Aged Care Facilities* (2022), https://www.health.tas.gov.au/sites/default/files/2022-10/vad_-_minimum_requirements.pdf.
[667] *Voluntary Assisted Dying Act 2019* (WA), s 31(5); *Voluntary Assisted Dying Act 2022* No 17 (NSW), s 21(3); *Voluntary Assisted Dying Act* 2017 (Vic), s 17; *Voluntary Assisted Dying Act 2021* (SA), s 31; *Voluntary Assisted Dying Act 2024* (ACT), s 100; *Voluntary Assisted Dying Act 2021* (Qld), s 16(4).
[668] See for example, *Voluntary Assisted Dying Act 2021* (SA), s 11.
[669] See for example, *Voluntary Assisted Dying Act 2021* (SA), ss 11, 25.
[670] See for example, *Voluntary Assisted Dying Act 2021* (Qld), s 90.
[671] See for example, *Voluntary Assisted Dying Act 2022* (NSW), ss 91-96.
[672] See for example, *Voluntary Assisted Dying Act 2022* (NSW), s 101.
[673] See for example, *Voluntary Assisted Dying Act 2021* (Qld), s 89.
[674] See for example, *Voluntary Assisted Dying Act 2021* (Qld), ss 91–96.
[675] See for example, *Voluntary Assisted Dying Act 2024* (ACT), s 108.

Evidence before the Committee

11.38 The Committee received varied evidence regarding the extent to which institutions should be able to choose not to participate in VAD and what obligations they must fulfil in relation to the person requesting VAD.

11.39 The Committee heard from AMSANT that primary healthcare services should be able choose not to participate, as provided for in other Australian jurisdictions:

> ...any legislation enabling VAD in the NT should not mandate primary healthcare services and individual clinicians to participate in VAD. Services and individual clinicians should be given the option not to participate which is in place in other jurisdictions.[676]

11.40 In Tennant Creek, it was noted that Pulkapulkka Kari Flexible Aged Care (Figure 17) is run by ARRCS which falls under the Uniting Church. Therefore, the facility would have to adhere to ARRCS's uniform position in opposition to VAD, despite an individual employee's personal beliefs about VAD.[677]

Figure 17: The Committee met with staff from Pulkpulkka Kari Aged Care Facility in Tennant Creek

[676] Aboriginal Medical Services Alliance NT, Public Hearing, Darwin, 5 August 2025.
[677] Meeting with Pulkapulkka Kari Flexible Aged Care, Tennant Creek, 27 August 2025.

11.41 Some written submissions stated their view that institutions should not have to participate in VAD in any way.[678] For example, the Catholic Diocese of Darwin stated:

> Forcing participation in euthanasia and assisted suicide would compromise professional integrity and erode trust in healthcare. The Northern Territory must ensure that both individual practitioners and institutions have the right to refuse involvement in euthanasia and assisted suicide without penalty or requirement to refer.[679]

11.42 However, most written submissions that referred to this topic argued that institutions, such as aged care facilities and hospitals, should be able to choose not to participate but should not be able to hinder residents' right to access VAD.[680]

11.43 Voluntary Assisted Dying South Australia (VADSA) raised that it is preferrable to include provisions in the legislation, rather than in policy, that provide for institutional conscientious objection and that this would be particularly important in the NT to ensure equity of access to VAD across regional and remote areas:

> The Queensland [institutional conscientious objection] provisions are preferred as they are clearer and more comprehensive. VADSA views the [institutional conscientious objection] provisions as particularly helpful for people requesting VAD, for doctors and for the community because private hospitals are required to develop and have available their policy on VAD. In Victoria, WA and Tasmania, where there are no [institutional conscientious objection] provisions, private hospitals are not required to provide any information to patients, doctors or the community about their policy in relation to VAD, or to even have a policy.
>
> [Institutional conscientious objection] provisions would be particularly important in a Northern Territory VAD Act given the vast distances and fewer number of private hospitals. Such public information would enable health professionals and people requesting VAD to more efficiently plan and manage a request for assisted dying. Our experience in South Australia is that [institutional conscientious objection] provides additional safeguards for both health professionals and the person requesting VAD.[681]

11.44 Professor Ben White and Lindy Willmot supported inclusion of institutional objection provisions in the legislation as well "so that such objection does not result in harm to the resident or patient of that institution" and does not force a person "to choose between accessing VAD and remaining in an institution which is their home".[682]

11.45 Dying with Dignity Victoria cited the Queensland model as the preferred model as it "is the best way to balance the interests of people seeking VAD and non-participating institutions".[683] Dying with Dignity NSW expressed support for a similar model.[684]

11.46 A few submissions also suggested a requirement for institutions to ensure their objection to VAD is communicated clearly on their website and/or in marketing materials.[685]

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[678] Submissions 18, 97.
[679] Submission 97.
[680] Submissions 108, 125, 136, 203, 257, 319, 321.
[681] Submission 136.
[682] Submission 5, 13.
[683] Submission 125.
[684] Submission 321.
[685] Submissions 108, 257, 321.

11.47 Dying with Dignity WA and Go Gentle Australia argued that institutions should not have a right to choose not to provide VAD services, with Go Gentle Australia going a step further by presenting the idea that institutions do not have a conscience and should therefore not even be able to declare a conscientious objection to VAD. However, both of these submitters agreed that if the NT was to allow institutions to choose not to participate, the model outlined in other states should be implemented.[686]

11.48 The Committee also received evidence from Alice Springs Hospital expressing reservations about the delivery of VAD services on site. Dr Chris Andersen, Specialist Doctor, Palliative Care, who was also on the 2024 Expert Panel representing Central Australia, explained the hospital's concerns to the Committee:

> I think voluntary assisted dying has to come here there is no way we can be the only jurisdiction that doesn't have it. Particularly given our history and it's very important we get it right for us because we deal with dying people all the time we have these conversations with people. We don't hear a lot of people actually requesting VAD but it does happen periodically; not much amongst Aboriginal people almost never in my experience in fact.
>
> But none the less there is definitely, and having been on the panel I know in terms of public discussion there is a big sense of like; 'this has to happen here'.
>
> …We do have a lot of… concerns about what may be the unintended consequences if we don't do it well… So look we support people who want and are eligible for VAD to have access to it and we will take them on as our clients and look after them as our patients.
>
> But I think what is important for us in palliative care is that we don't get identified as the VAD providers. Because what that does is it means all the other people who don't want VAD and are scared of palliative care and are already are often freaked out and anxious about coming towards us anyway; hesitant, frightened, they think our medications are killing them; we deal with that stuff every single day it has always been an issue in palliative care; "What is that medication for?" "What did you just give my mother"? And here for many Aboriginal people in particular there is a real mistrust or anxiety to health care, they don't always feel that safe in hospital with doctors. So we have built a service that has become very acceptable… something that families will readily use.
>
> And so we have a real concern that the way that is implemented here needs to protect what we have… and the access to that service for people who are going to be using VAD or wanting VAD. So that is our big worry I think we are going to have to be really creative about how we do things here because we don't have many clinicians who would probably like to be VAD providers. And we don't have many alternative options; like there is no private hospital here…
>
> Aboriginal Community Controlled Health Organisations or… people who work across those two sites it's going to be quite hard. I think in a decade it will be different but certainly for I think the first five years it is going to be quite challenging as this gets socialised in our community. We are a very unique and special place here, very special. But we deal with a lot of dying people and very tragic, untimely, frequency of deaths in our community. It is very different from anywhere else I have ever worked.[687]

[686] Submission 203.
[687] Meeting with Alice Springs Hospital Palliative Care team, Alice Springs, 21 August 2025.

11.49 The CHO and CMO, NT Health respectfully acknowledged this concern and discussed how any VAD service would most likely evolve over time.[688] The CMO advised that:

> I think it is important to understand also that in other jurisdictions, as VAD is introduced, perceptions and assumptions are unpacked and untangled, and the concepts of death and dying, with increased health literacy and improved communication and understanding, changes and becomes much more nuanced and complex. I think it is challenging from the outset to say that VAD will never happen in a particular type of facility, in an NT Health facility, et cetera.[689]

11.50 Institutional objection had negative impacts on individuals seeking VAD, as well as their families. In the case of one individual, Go Gentle Australia stated:

> Faced with a drawn out and painful death from a rare duodenal cancer, 37-year-old Fraser Cahill chose to access voluntary assisted dying (VAD). Determined to stay in control of his dying, the first thing Fraser said to his care team was that he wanted to die at the beach. He also wanted a final family dinner the night before so he could say everything that needed to be said. Fraser's VAD care team immediately swung into action to fulfill his wishes. But not everyone was so supportive. The Catholic hospital where Fraser was an inpatient objected to being involved in any facet of the VAD process. Not only did they forbid VAD assessors from coming onto the premises, they even refused to allow VAD conversations. Fraser's mum Mandy said the family had to resort to sneaking Fraser out for appointments with the VAD facilitators. "We didn't tell the senior staff, who had made it clear they did not approve," she recalled. "The doctors and the staff weren't allowed to talk about it, which we found quite incredible. This was Fraser's choice after all." After he was approved for VAD, the family was forced to continue the subterfuge or risk jeopardising Fraser's plans. "In the end we had to smuggle him out," his brother Wes said. "It was very poor form and far more stressful than it needed to be. If he'd known, Fraser would have chosen a different hospital." The family believes no institution should have the right to deny someone's end-of-life choice.[690]

[688] NT Health, Public Hearing, Darwin, 5 August 2025.
[689] NT Health, Public Hearing, Darwin, 5 August 2025.
[690] Submission 203.

Case study: Impact of Institutional Objection on People and Their Families

In 2023, Professor Ben White, Dr Ruthie Jeanneret, Dr Eliana Close and Professor Lindy Willmott published a study on the impact of institutional objection on people seeking VAD, their families and caregivers in Victoria.[691] The study involved interviews with family caregivers and patients between August and November 2021. The study noted a range of basis for objection, including religious reasons and palliative care philosophy. The study found institutions objected to certain practices and which results in:

- Restrictions on access eligibility assessments onsite (including in residential facilities), with some institutions barring entry for health practitioners;
- Preventing access to the VAD Substance, including denying access to the Pharmacy Service to enable delivery;
- Prohibitions on the VAD Substance from being taken or administered onsite; and.
- Preventing employees from attending VAD administration.

This resulted in a number of negative impacts on patients and their families. The study found:

- People experienced delays in accessing VAD due to prohibitions on health practitioner or pharmacy access or waits to leave the facility before they could take the VAD Substance. This was challenging for patients with rapid illness progression and people living in residential facilities;
- Institutional objection impacted people's choice about the place and time of VAD administration. Sometimes beds were not available in other institutions and the person had to be transferred to the family home for VAD administration, which was not their preferred place to die; and.
- People experienced adverse emotional experiences, including feelings of anger and frustration, as well as fear and stress at the prospect of continued suffering and uncertainty. Many people lost trust in the objecting institution. One family caregiver stated:

> It will always be a great sadness for me that the last few precious hours on Mum's last day were mostly filled with stress and distress, having to scurry around moving her out of her so-called 'home'.

The study found there are some mediating influences to institutional objection which compound or soften the impact on patients. A significant factor to that softening the impact of institutional object was supportive staff in the institution.

Committee comments

11.51 The Committee believes it is vital to balance the rights of institutions to conscientiously object with the rights of individuals to access end-of-life care. The Committee notes that some health services and institutions will chose not to

[691] B. White et al., 'The impact on patients of objections by institutions to assisted dying: a qualitative study of family caregivers' perceptions', *BMC Medical Ethics* 24 (2023).

participate in VAD. The Committee recognises the rights of these institutions to conscientiously object on number of grounds, whether they be religious, cultural or philosophical. This aligns with the approach taken in other jurisdictions and the diversity of health services in the NT.

11.52 The Committee supports the ability for institutions to decline to allow VAD services from occurring on the premises. This includes making a request, undergoing an assessment, making an Administration Decision or administering the VAD Substance. The Committee understands this may conflict with an institution's values, purpose or mission, and raise concerns about the ability of an institution to provide culturally safe care for Aboriginal people. However, the Committee recognises this may impact on a person's ability to access VAD in these institutions. To alleviate this challenge, the Committee considers it appropriate to enable the transfer of a person to or from a place to where the relevant step in the VAD process can occur.

11.53 The Committee also considers it appropriate to ensure adequate information is available to persons seeking VAD to ensure they can make informed decisions about their healthcare. The Committee recommends institutions must not hinder access to information about VAD, must allow access to a VAD Care Navigator onsite, and must provide a requesting person with the contact details of the official VAD Care Navigator Service. An institution should also be required to advertise publicly that it does not participate in VAD. The Committee considers this approach ensures that individuals can make informed choices about their care while respecting the institution's right to conscientiously object.

11.54 The Committee notes that, while some jurisdictions have remained silent on institutional objection in their legislation, others have specified the rights and obligations of institutions in their legislation. The Committee considers that the issue of a person's access to VAD in a health or care entity should be set out in legislation as this will provide direction and certainty in relation to the relative rights and responsibilities of health or care entities and people seeking access to VAD.[692] The Committee notes that policy-only responses in other jurisdictions have been reported to have caused challenges in practice.[693] However, the Committee recognises that policy will also be needed to accompany the legislation in the NT to provide practical guidance on entities' obligations within the framework.

11.55 Accordingly, the Committee does not adopt Recommendation 4 of the 2024 Report that relates to the obligations of residential facilities in relation to VAD. The Committee supports the suggestion of the Panel in the 2024 Report that the legislation should include provisions requiring health or care entities which object to participating in VAD to advertise or communicate their objection to others.[694]

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[692] B. P White, L. Willmott and E. Close, 'Legislative Options to Address Institutional Objections to Voluntary Assisted Dying in Australia' (2021), *University of New South Wales Law Journal Forum*, 3(3), p. 14.

[693] B. P. White et al., 'The Impact on Patients of Objections by Institutions to Assisted Dying: A Qualitative Study of Family Caregivers' Perceptions' (2023), *BMC Medical Ethics*, 24(22).

[694] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 41.

General

Recommendation 54

The Committee recommends that the legislation should provide a definition of a 'health or care entity' or other term that covers health entities providing health and/or care services including:

a. Public and private hospitals;

b. Hospices; and

c. Residential aged care facilities, nursing homes or other facilities at which care is provided to persons who, because of infirmity, illness, disease, incapacity or disability, have a need for nursing or personal care.

Recommendation 55

The Committee recommends that health or care entities that object to VAD may refuse to participate in VAD.

Notifications about VAD

Recommendation 56

The Committee recommends that the legislation should provide that all health or care entities which do not participate in VAD must:

a. advertise this position publicly in a way that is likely to be accessed by prospective residents and/or patients; and

b. notify persons in the health or care entity (including residents and patients) who express a wish to access VAD of this position.

Obligations to refer and allow access to information

Recommendation 57

The Committee recommends that the legislation should provide that, if a person is receiving relevant services (a health service, residential aged care or a personal care service) from a health or care entity and the person asks for information about VAD and the entity does not provide the requested information, the health and care entity must:

a. provide the person with the contact details of the official VAD navigator service;

b. not hinder the person's access at the health and care entity to information about VAD; and

c. allow reasonable access to the person at the health and care entity by a member or employee of an official VAD care navigator service.

Recommendation 58

The Committee recommends that the legislation should provide that a health or care entity must not prevent or prohibit an employee or healthcare worker onsite from

initiating conversations about VAD or otherwise providing information about VAD to persons in accordance with the legislative provisions described in Recommendation 14.

Obligations to facilitate transfers

Recommendation 59

The Committee recommends that the legislation provide that, if a person or the person's agent advises the health or care entity that the person wishes to undergo a step in the VAD process and the entity does not wish to allow this to occur onsite, relevant steps in the VAD process include:

a. making a First or Formal Request for VAD;

b. undergoing a First Assessment or a Second Assessment for VAD;

c. making an Administration Decision; and

d. administering the VAD Substance.

Recommendation 60

The Committee recommends that the legislation provide that the health or care entity must take reasonable steps to facilitate the transfer of the person to (and from, if required) a place where the relevant step in the VAD process may be carried out by a health practitioner who is able to facilitate this step for the person.

12 Accountability, offences and protections

Overview

12.1 VAD frameworks require a range of oversight and compliance mechanisms to ensure compliance with the legislation. The 2024 Expert Panel Report made a range of recommendations relating to accountability, offences and protections. This Chapter discusses these recommendations.

Review Board

12.2 The 2024 Expert Panel recommended that an independent statutory body (Review Board) should be established to monitor compliance in every VAD case and to review the operation of the Act.[695] The functions, membership and responsibilities of the Review Board were outlined in Chapter 6 of the 2024 Expert Panel Report.[696] The Committee supports the Expert Panel's recommendation in part.

Approaches in other jurisdictions

12.3 Most Australian jurisdictions have a statutory review mechanism with the function of investigating compliance and operation of their VAD scheme and legislation.[697] In some States, such as Victoria and SA, oversight is prospective. This may include reviewing and approving applications for VAD in every case (i.e., before a person can proceed to the next stage of the VAD process). In contrast, Review Boards in other States, such as Queensland, also exercise retrospective oversight by reviewing actors' compliance at the end of the process. The 2024 Expert Panel Report proposed that the Review Board would perform both prospective and retrospective oversight.

12.4 Oversight bodies in other jurisdictions have enforcement powers and the ability to refer suspected breaches to external authorities, including the police, Coroner or the AHPRA. Some States, such as Tasmania, grant their oversight body an investigative function, allowing them to directly investigate suspected breaches or refer them.

12.5 The 2024 Expert Panel Report proposed that the Review Board should have the power to request information from the CEO of NT Health, any accredited person in the VAD process, a Contact Person or a treating medical practitioner.[698] In other jurisdictions, the Review Boards are required to report annually.[699]

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[695] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), Recommendation 19.

[696] *NT Government, Voluntary Assisted Dying Independent Expert Panel, Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024 (2024)*, Recommendation 19.

[697] *Voluntary Assisted Dying Act 2017* (Vic), s 92; *Voluntary Assisted Dying Act 2019* (WA), s 164; *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas), ss 110, 114-121; *Voluntary Assisted Dying Act 2021* (SA), s 113; *Voluntary Assisted Dying Act 2021* (Qld), Part 8; *Voluntary Assisted Dying Act 2022* (NSW), Parts 7 and 8; *Voluntary Assisted Dying Act 2024* (ACT), Part 8.

[698] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 79.

[699] See, for example, *Voluntary Assisted Dying Act 2018* (Vic), s 93(1)(c); *Voluntary Assisted Dying Act 2024* (ACT), s 127.

12.6 The Panel found that the Queensland legislation provided a clear and succinct description of a Review Board's functions and powers, being to:

- Monitor the operation of the Act;
- Monitor compliance with VAD processes in all cases and report any issues of non-compliance to relevant authorities;
- Review all VAD cases including cases that do not involve the complete death by assisted dying under the Act;
- Provide advice, information and reports to government including an annual report on the operation of the Act and recommendations for continuous improvement;
- Oversee the setting of standards for experience and practice; training and qualification requirements for all persons involved in providing VAD services;
- Oversee the provision of community education and resources;
- Oversee the provision of education and resources for health professionals;
- Facilitate the conduct of research, review and analysis in relation to information provided to the Review Board by practitioners;
- Collect, use and disclose data or information in relation to the Act for the purposes of performing its functions;
- Facilitate the statutory review of the Act;
- Any other functions under the Act
- Oversee development, implementation and any necessary adjustment of clinical guidelines relating to VAD processes.

12.7 Membership requirements differ across other jurisdictions. The number of members on VAD Review Boards, or the Commission as is the case in Tasmania, currently range from five in WA and NSW up to nine in Victoria and Queensland.

12.8 In the NT it was proposed in the 2024 Expert Panel Report that membership of the Review Board should reflect the geographic and cultural diversity of the Territory. This includes an Aboriginal person to provide guidance on matters sensitive to Aboriginal culture and traditions, and regional representation with potentially at least one health practitioner member practicing in Central Australia.

12.9 The types of expertise sought for VAD Review Boards interstate typically include a mixture of clinical, nursing, pharmaceutical, legal, palliative, human rights, Aboriginal healthcare and cultural expertise and in some instances a consumer/community representative. The 2024 Expert Panel stopped short of specifying that level of detail regarding Board composition.

Evidence before the Committee

12.10 Most of the written submissions to the inquiry that highlighted the need for robust oversight mechanisms discussed the merits of establishing a VAD Review Board, favourably referencing the proposal by the 2024 Expert Panel.[700]

Independence

12.11 The importance of the Board being independent was explained to the Committee by the AMA NT:

> The independence of the Review Board I think is a really important part of the openness and transparency that we will need for a service like this. Despite VAD being incredibly popular with the group of people who have elected you, basically, there is still very strong opposition around moral and ethical grounds, so anything we have to do has to be very open and transparent. Everything we do should be, but in this case in particular, we really have to cross our 'T's and dot our 'I's. I think the independence of that Review Board is paramount in that respect. I see the VAD service as providing the reports and the Review Board as being the scrutiny, therefore they probably should be separate.[701]

12.12 Similarly, Go Gentle Australia recommended an independent entity:

> …the creation of an oversight body, independent of government. We believe a board or commission is best served by members with a wide range of experiences and backgrounds. For example, Victoria's Voluntary Assisted Dying Review Board was chaired through its first two years by a retired Supreme Court judge and included among its members a neurologist, an oncologist, a palliative care specialist, a professor of nursing, and a consumer representative. Other states' Boards have similar varied expertise.[702]

12.13 The Committee discussed the merits of appointing the CHO as the Chair of the Review Board with NT Health. Dr Kane Vellar, Clinical Subject Matter Expert and former Expert Panel member advised that:

> it was our view that would be an independent body, so completely separate to NT Health, in terms of what it would look like, potentially a statutory body where that independent body holds a responsibility to reviewing the practices and maintaining the appropriate compliance with legislation.[703]

12.14 Following on from that point, the CHO explained that:

> A survey of other jurisdictions, it [VAD Review Board] has been truly independent. Of course, the Northern Territory reserves the right to chart their own course. The pros and cons—the pros would be that there always needs to be a CHO under Northern Territory legislation. That is a statutory role that must be always filled, so there is certainty of continuity of that role being existent. The CHO, it is possible to that as an oversight. Perhaps there must be some instructions there about the position of the CHO being perhaps an independent Chair or something like that. That would give comfort to the board that they had the ability to make their decision on the board's composition and the board's merit. The true concept

[700] Submissions 4, 21, 24, 33, 34, 53, 58, 69, 71, 72, 109, 161, 170, 203, 389.
[701] Australian Medical Association NT, Public Hearing, Darwin, 5 August 2025.
[702] Submission 203.
[703] NT Health, Public Hearing, Darwin, 5 September 2025.

> here is that the board is empowered to have that independence and does not have unnecessarily a CHO overriding their decisions necessarily.[704]

Membership

12.15 The need for Aboriginal and Torres Strait Islander representation on a Review Board was emphasised in submissions and evidence to the Inquiry.[705] The Urapuntja Health Service Aboriginal Corporation advised that to ensure VAD is delivered safely and effectively there needs to be a culturally informed Review Board to oversee implementation and provide independent oversight.[706] It also recommended that Review Board annual reporting include disaggregated data on Aboriginal and remote access, cultural safety issues and community feedback. Dying with Dignity Queensland similarly suggested the NT should "embed cultural representation on the Review Board to ensure oversight reflects First Nations perspectives".[707]

12.16 Regarding the membership of the Review Board, Dr John Zorbas, President of AMA NT, stated:

> Recognising that the composition of the VAD Review Board would have to be legally empowered to oversee the process. There needs to be a senior physician on that board, whatever that board and its composition might look like, with an effective ability to influence how VAD is operated in the NT. That would most likely be a palliative care physician. We also need representation from appropriate nursing, legal and pharmacy, but that is outside my representative body.
>
> Aboriginal health experts would also be necessary—I would defer to bodies like AMSANT to provide you with more information about who would be best in that space to represent that view—and community representatives to make sure that the service is servicing the need of the community from their standpoint rather than ours.[708]

12.17 Ensuring the Board reflects the NT's multicultural communities was raised as an issue by the Clem Jones Group.[709] The Pharmacy Guild of Australia expressed its support for a pharmacist to be on the Board given that "the management of the VAD medicine is a critical element of the service".[710]

12.18 A small number of people making submissions envisage an expanded role for the Coroner and advocated for the inclusion of a representative opposing VAD on the VAD Review Board.[711]

Functions

12.19 Some stakeholders considered the functions of the Review Board. Many people supported the 2024 Expert Panel Report recommendations regarding aligning the functions of the Review Board with Queensland's approach.[712]

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[704] NT Health, Public Hearing, Darwin, 5 September 2025.
[705] Submissions 91, 136, 161.
[706] Submission 22.
[707] Submission 91.
[708] Australian Medical Association NT, Public Hearing, Darwin, 5 August 2025.
[709] Submission 161.
[710] Submission 167.
[711] Submissions 79, 81, 112, 149, 154, 334.
[712] Submissions 91, 109.

12.20 The Committee heard a small number of views that additional or fewer functions should be required. Dying with Dignity ACT considered that requirements to notify the VAD Review Board at every step of the process are too onerous and may cause delays to a person accessing VAD.[713] By contrast, the SA VAD Review Board highlighted the importance of prospective review:

> To ensure safe and compliant operation of VAD across the State, the Review Board conducts a detailed compliance review of each individual patient's VAD pathway, completing over 900 reviews since commencement of VAD. These reviews demonstrate a high level of compliance with the legislation, a testament to the safe systems, processes and people involved in VAD on a day to day basis.[714]

12.21 AMA NT noted that the functions of the Review Board may develop over time, but highlighted the importance of reviewing every case:

> There would have to be case-by-case review of every case of VAD that we have, at least in the first year, and most probably ongoing, but I would leave that to future system design to decide on that.[715]

Committee comments

12.22 While the 2024 Expert Panel Report did not make a formal recommendation about the Review Board's membership, it identified that it should include cultural expertise and diversity, geographical and regional representation (which may include mandating that that at least one health practitioner member must be practising in Central Australia) as well as an Aboriginal person to provide guidance in relation to Aboriginal culture and traditions.[716]

12.23 The 2024 Expert Panel Report identified that the functions and powers of the Review Board should generally be consistent with those of the Queensland VAD Review Board included in Queensland's legislation,[717] and include some additional functions including facilitating the statutory review of the NT legislation.

12.24 The 2024 Expert Panel Report did not make a formal recommendation about data collection and sharing by the Review Board. It identified the importance of collecting information about the VAD process for a range of purposes including monitoring compliance and supporting the functions of the Review Board.[718]

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[713] Submission 101.
[714] Submission 132.
[715] Australian Medical Association NT, Public Hearing, Darwin, 5 August 2025.
[716] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 78.
[717] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 79. The Report states a number of matters that should specifically be included in the Review Board's functions and powers including: providing for referrals to other entities such as the Police Commissioner; requesting information from the CEO of Health and any accredited person providing any aspect of a VAD service (including interpreting, bereavement support or chaplaincy); and requesting information from a Contact Person or a treating medical practitioner of an eligible person. Each of these functions are possible under the Queensland legislation's functions and powers of the Review Board (so are encompassed in the proposed drafting instructions).
[718] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 80.

12.25 Accordingly, the Committee is of the view that there should be an independent statutory VAD Review Board in the legislation.

12.26 The Review Board's functions should include:

- monitoring the NT's VAD system;
- oversight of individual VAD cases to ensure compliance; and
- reviewing the operation of the NT's VAD legislation.

12.27 The Committee is of the view that the unique environment of the NT necessitates a couple of marked departures from the Australian model of the VAD Review Board with:

- additional Aboriginal representation; and
- as a pragmatic measure, the appointment of the CHO as the Chair of the Board to utilise existing resources with statutory powers.

Recommendation 61

The Committee recommends that the legislation should establish a Review Board for VAD in the NT.

Recommendation 62

The Committee recommends that the legislation should provide a definition of a 'completed case' – where a person who has been assessed as eligible for VAD following a First Assessment and a Second Assessment has died whether following administration of a VAD Substance or another cause.

Recommendation 63

The Committee recommends that the legislation should provide that the Review Board should have the following functions, and the powers necessary to give effect to these functions:

a. To monitor the operation of the NT legislation;

b. To review each completed case including for whether the NT legislation was complied with by the relevant person(s) in each case;

c. To refer to the relevant entities issues identified by the Review Board in relation to VAD, including suspected non-compliance, including:

i. the Police Commissioner;

ii. Australian Health Practitioner Regulation Agency;

iii. the Coroner;

iv. the Aboriginal Health Service;

v. the CEO of the Department of Health; or

vi. the Health and Community Services Complaints Commission;

d. **To collect, record, use and keep data and information about requests for and provision of VAD (including information prescribed by Regulations) and disclose this information where appropriate or required for the purposes of performing its functions;**

e. **To analyse information given to the Board under the NT legislation and to research or facilitate research of matters related to the operation of the NT legislation;**

f. **To provide, on the Board's own initiative or on request, information, reports and advice to the Minister or CEO of the Department of Health in relation to:**

   i. **the operation of the NT legislation;**

   ii. **the Board's functions; or**

   iii. **the improvement of the process and safeguards of VAD;**

g. **To promote compliance with and understanding of the NT legislation, including by providing information and resources about the operation of the legislation to registered health practitioners and community members;**

h. **To oversee the setting of standards for health practitioner experience and practice, training and qualification requirements and interpreter requirements and exemptions;**

i. **To promote continuous improvement in the compassionate, safe and practical operation of the NT legislation;**

j. **To consult and engage with the community and any entity the Board considers appropriate in relation to VAD;**

k. **To facilitate the statutory review of the NT legislation;**

l. **To oversee the development and implementation of clinical guidelines relating to VAD processes; and**

m. **Any other function given to the Board in the NT legislation.**

Recommendation 64

The Committee recommends that the legislation should provide that the Board must provide information at regular intervals to the Coroner, including the number of completed cases.

Recommendation 65

The Committee recommends that the legislation should provide that the Board's powers must enable it to request information for the purpose of exercising its functions from:

a. **The CEO of the Department of Health;**

b. **Any person – accredited or otherwise – participating in VAD provision including people providing such services as interpreting, bereavement support or chaplaincy;**

c. **A Contact Person appointed for a person seeking access to VAD; and**

d. **A treating medical practitioner of an eligible person.**

Recommendation 66

The Committee recommends that the legislation should provide that the Board must act independently and in the public interest. The Board is not subject to direction by anyone, including the Minister, about how it performs its functions.

Recommendation 67

The Committee recommends that the legislation should provide that the CEO of the Department of Health must ensure the Board is provided with the staff, services and facilities, and other resources and support, that are reasonably necessary to enable the Board to perform its functions.

Membership of the Review Board

Recommendation 68

The Committee recommends that the legislation should provide that the Minister, on the recommendation of the Chief Health Officer, must ensure the membership of the Board:

a. **includes persons with a range of experience, knowledge and skills relevant to the Board's functions which may include clinical, legal, ethics, and cultural expertise; and**

b. **takes into account the social, cultural and geographic/regional characteristics of the NT community and reflects this diversity.**

Recommendation 69

The Committee recommends that the legislation should provide that, at a minimum, the Board must consist of:

a. **the Chief Health Officer (or other person to whom this role has been appropriately delegated by the Chief Health Officer) (see Recommendation 70);**

b. **one member who has clinical (including medical or nursing) expertise;**

c. **one member who has legal expertise;**

d. **one member who is an Aboriginal person in a position to provide and seek advice from First Nations peoples in relation to cultural matters relating to VAD; and**

e. **one member who is employed by or a representative of an Aboriginal Community Health Organisation in the NT.**

Recommendation 70

The Committee recommends that the legislation should provide that the Chief Health Officer is the Chairperson of the Board and is responsible for leading and directing the activities of the Board to ensure it performs its functions appropriately. The Chief

Health Officer is permitted to delegate the role of Chairperson to another appropriately qualified person in accordance with the usual processes for delegation.

Recommendation 71

The Committee recommends that the legislation should provide that a Deputy Chairperson should be appointed to act in the role of Chairperson during a vacancy in the office, or absence of the Chairperson.

Recommendation 72

The Committee recommends that the legislation should provide that, in the event that the Board requires expert advice in relation to cultural matters, including cultural safety, the Board should seek the required advice from the relevant people.

Other provisions

Recommendation 73

The Committee recommends that other provisions should also be included in the legislation relating to:

a. The membership and roles of the Board:

i. the roles and responsibilities of the Board's Chairperson and Deputy Chairperson;

ii. term of appointment for members;

iii. appointment and reappointment of members;

iv. vacation of office;

v. persons unable to be appointed as members; and

vi. conditions of appointment.

b. The proceedings of the Board, including conduct of meetings, disclosure of interests and the voting of members on referrals to relevant entities in Recommendation 63(c), above;[719] and

c. miscellaneous provisions.[720]

Reporting

Recommendation 74

The Committee recommends that the legislation should provide the Board must provide an Annual Report to the Minister reporting on the performance of the Board's functions within the financial year within six months of the end of the financial year. This report must include:

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[719] Reference could be had to Part 8 Division 3 of the *Voluntary Assisted Dying Act 2021* (Qld) in relation to these provisions.

[720] Reference could be had to Part 8 of the *Voluntary Assisted Dying Act 2021* (Qld) in relation to these provisions.

a. **Information on the operation of the NT legislation including the number of completed cases of which the Board has been notified in the financial year;**

b. **Recommendations of the Board relevant to the performance of its functions, including recommendations about systematic matters in VAD or the improvement of VAD; and**

c. **A de-identified summary of the information required to be collected and kept by the Board under Recommendation 63(d) above.**

Recommendation 75

The Committee recommends that the legislation should provide that the Minister must table a copy of the Annual Report in the Legislative Assembly within 14 sitting days after receiving it.

Appeal mechanisms

12.28 In every Australian jurisdiction, there is a legal right to challenge certain decisions made regarding a person's eligibility to access VAD. This allows a person to request that another person, other than the original decision-maker, review the decision, reconsider the facts and laws, and determine whether the original decision was correct.

12.29 The 2024 Expert Panel Report recommended that:

- There should be a right of review to the Northern Territory Civil and Administrative Tribunal (NTCAT) for some VAD decisions on eligibility;
- Only the person seeking access to VAD should have the right of review on the basis that family members could initiate unwanted legal proceedings to try to prevent a person from carrying out their wishes to access VAD; and
- The VAD legislation should expressly preserve the inherent jurisdiction of the Supreme Court.[721]

12.30 NTCAT is the NT's administrative tribunal. It is the main forum for resolving smaller legal disputes, reconsidering government decisions and helping ensure that certain important human rights are respected.[722]

12.31 In common law, superior courts have an inherent jurisdiction to conduct judicial review.[723] The Expert Panel noted that a provision protecting this inherent jurisdiction would "…preserve entirely the jurisdiction of the Supreme Court to hear a matter in appropriate circumstances. However, the Court would have regard to the Act and the

[721] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), Recommendation 20.
[722] Northern Territory Civil and Administrative Tribunal, *About us* (2025), https://ntcat.nt.gov.au/about-us.
[723] Australian Law Reform Commission, *Traditional Rights and Freedoms—Encroachments by Commonwealth Laws (ALRC Report 129)* (2016), p. 414.

availability of review mechanisms within the Act as a matter of discretion in deciding whether or not to hear a matter, either on an urgent basis or at all".[724]

12.32 The Committee partially supports the appeal mechanisms recommendation of the 2024 Expert Panel Report. The Committee is of the view that a wider range of persons should be permitted to seek review of VAD decisions than is provided for in the 2024 Expert Panel Report, which is in line with the Australian model of VAD.

Approaches in other jurisdictions

Administrative tribunal

12.33 In most jurisdictions, the State's administrative tribunal allows for an independent reconsideration of the eligibility decision. Eligibility decisions that may be reviewed include:

- whether the person meets the residency requirements (including eligibility for exemption);
- whether the person does, or does not, have decision-making capacity; and
- whether the person is, or is not, acting voluntarily and without coercion.[725]

12.34 Alternative models could include judicial review (NSW) or review by the VAD Commission as an independent statutory body (Tasmania).

Who can apply for review

12.35 In other Australian jurisdictions, persons permitted to seek review include an agent of the person or another person who has a relevant interest in the person seeking access.[726]

12.36 Including this third category of 'interested persons' permits a member of the person's healthcare team, a family member or carer to seek review of a decision and, in so doing, act in the interests of the person. For instance, a medical practitioner may seek review of their own assessment with respect to the person's ineligibility as part of exploring whether, in fact, the person should be eligible on this basis. For example, a medical practitioner may be unsure if a person meets residency requirements.

Timeframes for review

12.37 Most jurisdictions specify a period after a decision has been made within which a person may request a review. In general, this is five business days (Queensland) or 28

[724] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 81.
[725] See for example, *Voluntary Assisted Dying Act 2019* (WA), s 84(1); *Voluntary Assisted Dying Act 2021* (QLD), s 99.
[726] See for example, *Voluntary Assisted Dying Act 2019* (WA), s 83; *Voluntary Assisted Dying Act 2022* (NSW), s 108.

business days (SA) for decisions about eligibility.[727] A person must apply within this period to be eligible for review of the decision.

Jurisdiction of the Supreme Court

12.38 In NSW, Tasmania and WA, the Act specifies that nothing in the Act is intended to limit the inherent jurisdiction of the Supreme Court.[728]

Evidence before the Committee

12.39 The Committee received very limited evidence on this topic. Dr John Zorbas, President of AMA NT, told the Committee that NTCAT would be an appropriate "final point of appeal" to review decisions on residency requirements:

> A body like the NTCAT, as a right of appeal to what we decide is an appropriate residency situation or not, as long as the spirit of the language is around, having that connection to the NT and they have a legal right of appeal—I would have to defer to my legal colleagues on what that would look like—we would support that.[729]

12.40 AMA NT was also of the opinion that review requests should be confined to the person requesting VAD:

> [NTCAT] is an important safeguard. The AMA NT supports this recommendation, with the critical caveat that the right to apply for such a review must be limited to the person seeking access to VAD. This provides an essential avenue for recourse for the patient without opening the process to potentially vexatious or distressing legal challenges from family members or other parties who may disagree with the patient's autonomous decision.[730]

12.41 Another submission contended that eligibility decisions should not be reviewed by a tribunal, court or other body:

> …because those conducting the review would not have the same insight to the patient's circumstances. It would also prolong the process causing further pain, suffering and distress for the patient.[731]

[727] In NSW there is no legislated period after a decision has been made within which a person may request review by the Supreme Court under *Voluntary Assisted Dying Act 2022* (NSW), ss 109(1)(a-d).
[728] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 81.
[729] Australian Medical Association NT, Public Hearing, Darwin, 5 August 2025.
[730] Submission 368.
[731] Submission 108.

Figure 18: The Committee enroute to Numbulwar, flying over Ngukurr

Committee comments

12.42 The Committee proposes to follow the Australian model of VAD by legislating that the NTCAT should have jurisdiction to review eligibility-related VAD decisions.

12.43 The Committee observes that permitting an agent of the person seeking VAD to apply for review extends the ability of the person affected by the decision to seek review if they are unable or too unwell to do so themselves. Therefore, the person seeking VAD and an agent of the person should be permitted to apply for the review of a decision.

12.44 The Committee acknowledges concerns about the potential for someone to inappropriately attempt to block a person's access to VAD if the model of allowing a third party to seek review is adopted, and the concern that reviews could negatively impact the person seeking VAD.

12.45 To prevent this, the Committee proposes that the NTCAT should be granted responsibility for deciding whether a person falls into this third category of interested persons. The NTCAT would decide whether a person has sufficient and genuine interest in the rights and interests of the person who is subject to the decision. The Committee notes that a person's chosen agent is highly unlikely not to act in the interests of the person seeking VAD. Therefore, the interests of the person seeking VAD is protected by limiting the groups of people who may seek a review.

12.46 The Committee notes that applications to NTCAT must generally be made within 28 days of the relevant decision.[732] Consideration may need to be given to the interaction between VAD legislation and the *Northern Territory Civil and Administrative Tribunal Act 2014* (NT), including exemptions or modifications to its operation that may be required to enable different review periods.

12.47 The Committee agrees that the inherent jurisdiction of the Supreme Court should be preserved, so that it may hear cases relating to VAD as appropriate. The Committee notes this will protect individuals' common law right to judicial review.

Recommendation 76

The Committee recommends that the legislation should provide for definitions relevant to the following proposed legislative content, including definitions of:

- **a. reviewable decision:**
  - **i. whether a person meets the residence requirements (including eligibility for exemption);**
  - **ii. whether the person has decision-making capacity in relation to VAD; and**
  - **iii. whether the person is acting voluntarily and without coercion;**
- **b. eligible person:**
  - **i. person who is subject of the decision;**
  - **ii. their agent;**
  - **iii. the Coordinating or Consulting Practitioner for the person; or**
  - **iv. any other person who the NTCAT considers has sufficient and genuine interest in the rights and interests of the person subject of the decision in relation to VAD.**

[732] *Northern Territory Civil and Administrative Tribunal Act 2014* (NT), s 35(3).

Recommendation 77

The Committee recommends that the legislation should provide:

a. **That an eligible person can apply to NTCAT to seek review of a reviewable decision.**

b. **That the effect of making an application is that the VAD process is suspended and no further steps may be taken until the application is finalised, withdrawn (including if the person dies), or dismissed.**

c. **If the NTCAT's decision is that the person:**

   i. **does meet the residence requirements;**

   ii. **has decision-making capacity in relation to VAD; or**

   iii. **is acting voluntarily and without coercion;**

   the effect of NTCAT's decision is that the VAD process is no longer suspended and if the reviewable decision is to be set aside, the NTCAT's decision replaces the reviewable decision.

d. **If the NTCAT's decision is that the person:**

   i. **does not meet the residence requirements;**

   ii. **does not have decision-making capacity in relation to VAD; or**

   iii. **is not acting voluntarily and without coercion;**

   the effect of the NTCAT's decision is that the person is ineligible for VAD, the VAD process ends and no further steps in the VAD process can be taken.

e. **That the NTCAT should provide a written statement of reasons for the decision made in relation to a review of a reviewable decision.**

f. **For other procedural provisions relating to the conduct of reviews by NTCAT in relation to VAD.**[733]

g. **That nothing in the NT legislation affects the inherent jurisdiction of the Supreme Court.**

Review of legislation

12.48 Review provisions are a mechanism for ensuring legislation is properly evaluated after it has been in operation for several years. In other jurisdictions, the VAD Acts require the responsible Minister to review the operation of the VAD Act and table a report in the Parliament.[734] Reviews may look at the operation, scope or effectiveness of the Act.

[733] Reference could be had to Part 7 Divisions 3-4 *Voluntary Assisted Dying Act 2021* (QLD) which outlines procedural provisions for the Queensland Civil and Administrative Tribunal's (QCAT's) review of eligibility decisions.

[734] See for example, see *Voluntary Assisted Dying Act 2024* (ACT), ss 162(1) and (3).

12.49 In the 2024 Expert Panel Report, it was proposed that the NT completes a review on the third anniversary after the commencement of VAD legislation, and then every five years.[735] The Committee supports Recommendation 21 of the 2024 Expert Panel Report.

12.50 The 2024 Expert Panel Report did not include a formal recommendation about specific matters that must be considered as part of the first and subsequent reviews of the legislation, or the timeframe for tabling a report of the review.

Approaches in other jurisdictions

12.51 The timeline for the review of VAD Acts varies across jurisdictions, with some jurisdictions conducting reviews:

- every five years (Victoria, SA);[736]
- on the second anniversary after the Act commenced and then every five years (WA, NSW);[737]
- as soon as practicable three years after the Act commenced and then in accordance with the usual legislative review process (Queensland);[738] or
- on the third anniversary after the Act commenced and then every five years (Tasmania, ACT).[739]

12.52 Some jurisdictions specify high-level matters that must be included in the first review of their VAD Act, including principles in the legislation[740] and eligibility criteria.[741] Some jurisdictions include specific matters for consideration. For example, the ACT requires its first review in 2027 to consider whether residency requirements remain appropriate, whether a child with decision-making capacity should be able to access VAD, and whether VAD may be accessed via advanced care planning.[742] NSW requires consideration of equity of access across the state.[743]

12.53 All Australian jurisdictions require the Minister to table the report in the Parliament. Requirements for when the report must be tabled differs across jurisdictions, including:

- within six sitting days (SA);[744]
- within five sitting days (Tasmania);[745]

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[735] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), Recommendation 21.
[736] *Voluntary Assisted Dying Act 2017* (Vic), s 116; *Voluntary Assisted Dying Act 2021* (SA), s 129.
[737] *Voluntary Assisted Dying Act 2019* (WA), s 164; *Voluntary Assisted Dying Act 2022* (NSW), s 186(1).
[738] *Voluntary Assisted Dying Act 2021* (QLD), s 154(1).
[739] *End-of-Life Choices (Voluntary Assisted Dying) Act* 2021 (Tas), ss 145(1)–(4); *Voluntary Assisted Dying Act 2024* (ACT), ss 162(1) and (3).
[740] *Voluntary Assisted Dying Act 2022* (NSW), s 186(2).
[741] See, for example, *Voluntary Assisted Dying Act 2021* (QLD), s 154(2).
[742] *Voluntary Assisted Dying Act 2024* (ACT), s 162(2).
[743] *Voluntary Assisted Dying Act 2022* (NSW), ss 186(2)(a) and (b).
[744] *Voluntary Assisted Dying Act 2021* (SA), s 129(3).
[745] *End-of-Life Choices (Voluntary Assisted Dying) Act* 2021 (Tas), s 145(7).

- as soon as practicable after completing the review or the report is prepared (Queensland, NSW, WA);[746] or
- no specified timeframe (ACT, Victoria).[747]

Evidence before the Committee

12.54 Many stakeholders highlighted the importance of legislative review to the functioning of a VAD framework.[748] Stakeholders noted the review could allow for the incorporation of feedback on the functioning of the legislation from the public, people seeking VAD, service providers, and VAD practitioners.[749] Professor Ben White et al., explained:

> …many jurisdictions when passing VAD laws have mandated that reviews of the legislation occur after a specified period of time. Such a review should include issues that new jurisdictions would grapple with… but there is also scope after a VAD law is in operation to collect data about its functioning in practice… Generating concrete evidence about who is receiving access to VAD and who is being refused access helps determine whether eligibility criteria are operating as intended at the time the law passed. Such a review of how the law is being interpreted in practice also provides opportunities to support current approaches or correct them as needed.[750]

Timeframe for review of legislation

12.55 The Committee received evidence on the timeframe for completing reviews of the Act. Some stakeholders supported the 2024 Expert Panel Report's recommendation that the first review should occur three years after the commencement of the legislation, then every five years.[751] AMA NT stated:

> This schedule will allow for sufficient data and operational experience to be accumulated to inform a meaningful and evidence-based evaluation of the legislation's effectiveness and safety.[752]

12.56 Dying with Dignity Victoria suggested an initial three-year review, followed by a lengthened review timeframe, would suit the unique context of the NT:

> …a three year review cycle is optimal for a jurisdiction like the NT with unique geographic and demographic features that may result in unexpected challenges in implementation. The review cycle could be lengthened once operation of VAD laws has become more settled and is a more familiar part of the end of life landscape.[753]

12.57 Some stakeholders noted the Expert Panel's suggested approach was consistent with other jurisdictions.[754] Dr Kane Vellar, former member of the Expert Panel, noted the

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[746] *Voluntary Assisted Dying Act 2021* (QLD), s 154(3); *Voluntary Assisted Dying Act 2022* (NSW), s 186(3); *Voluntary Assisted Dying Act 2019* (WA), s 164(3).
[747] *Voluntary Assisted Dying Act 2024* (ACT), s 162(3); *Voluntary Assisted Dying Act 2017* (Vic), s 116(3).
[748] Submissions 196, 125, 134, 161, 84, 368, 377, 389.
[749] Submission 134.
[750] B. White et al., 'Who is eligible for voluntary assisted dying? Nine medical conditions assessed again five legal frameworks' (2022), *UNSW Law Journal* 45(1), p. 444.
[751] Submissions 125, 134; Australian Medical Association NT, Public Hearing, Darwin, 5 August 2025.
[752] Submission 368.
[753] Submission 125.
[754] Submission 134; NT Health, Public Hearing, Darwin, 5 August 2025.

rationale for the initial three-year timeframe is to ensure consistency with other jurisdictions:

> It was also in view of harmonising with other states and territories at the time of the VAD report so that we were able to ensure our legislation would be consistent with others so that a national harmonisation program with VAD could potentially be possible in the future. For that reason we stipulated approximately a three-year review of some of those legislative provisions so we could ensure that we remained consistent with other jurisdictions.[755]

12.58 Whilst there was broad support for the first review occurring after three years, other stakeholders suggested the periods for subsequent reviews should be shortened.[756] The Clem Jones Group stated:

> We believe all VAD laws should be reviewed at least every three years to enable them to more readily incorporate beneficial ideas from other jurisdictions, accommodate advances in medical science and treatments that may affect decisions by individuals considering seeking access to VAD, or to address in a timely manner potential problems that may arise within the operation of their schemes.
>
> Three-year reviews would also optimise opportunities, where they arise, for the timely harmonisation of VAD laws across Australian jurisdictions.
>
> We further believe that jurisdictions whose VAD laws currently do not provide for ongoing reviews should amend those laws to mandate three-yearly reviews.
>
> We also see benefits in specifically stating in an NT VAD law that in addition to the operation and effectiveness of the law and any NT VAD scheme, ongoing periodic reviews should also consider eligibility criteria for scheme applicants.[757]

Matters to consider in reviews of the legislation

12.59 Stakeholders to the Inquiry suggested particular matters that should be reviewed, including eligibility criteria. In particular, a number of stakeholders argued that decision-making capacity criteria, the use of advanced care directives and excluded conditions, such as dementia, Alzheimer's and mental illness, should be included in future reviews of the legislation.[758] In Tennant Creek, Jacqueline Bethel, CEO of Tennant Creek Mob Aboriginal Corporation stated:

> That needs to be reviewed. It is a really big omission. We understand the difficulties, but we believe that a bit more thought needs to be put into that rather than just putting it in the too-hard basket, particularly for early onset [Alzheimer's].[759]

12.60 National Seniors Australia pointed to the Canadian experience:

> We can take some inspiration from the Canadian situation, in which the VAD legislation passed in 2016 was slated for parliamentary review five years later. The Canadian review's purpose is threefold: to review how the legislation is working in general, to consider legally recognising advance requests for VAD by people

[755] NT Health, Public Hearing, Darwin, 5 August 2025.
[756] Submissions 84, 161.
[757] Submission 161.
[758] Submissions 25, 208, 389, 321; Meeting with Tennant Creek Mob Aboriginal Corporation, and community member in Tennant Creek Hospital, Tennant Creek, 28 August 2025; L. Willmott, B. White, C. Haining, 'Review of the Voluntary Assisted Dying Act 2019 (WA)' (2025), *Journal of Law and Medicine* 32(1), p. 160.
[759] Meeting with Tennant Creek Mob Aboriginal Corporation, Tennant Creek, 28 August 2025.

> with degenerative conditions such as dementia, and to consider extending VAD provisions to people suffering intolerably because of mental illness. This seems a very reasonable response to both needs and concerns and to the increasing engagement of members of the public in ethical deliberation about VAD. Australia would do well to follow suit.[760]

12.61 Other stakeholders expressed concerns about addressing excluded conditions in future reviews of the legislation, citing fears of a "slippery slope". [761] That is, the suggestion that the admission of a new eligible condition will cascade into or precipitate significant broadening of the categories of conditions and people who are deemed eligible for VAD. The term "slippery slope" is used widely by those who oppose VAD, however it is a contested idea.[762]

12.62 Other issues that stakeholders commented on for exploration in legislative reviews included:

- expanding the roles of health practitioners, including in relation to enabling nurse practitioners to conduct eligibility assessments;[763] and
- considering the VAD service delivery model.[764]

12.63 Some stakeholders highlighted the importance of ensuring legislative reviews have a focus on Aboriginal and Torres Strait Islander people's access to VAD and ensuring culturally safe care. Go Gentle Australia noted an 'Aboriginal model of VAD care' was the focus of Victoria's statutory review, facilitated by Karabena Consulting.[765] This is discussed further in Chapter 5.

Tabling review reports in Parliament

12.64 The Committee did not receive any evidence in relation to the timeframe for tabling reports of legislative reviews in the Legislative Assembly.

Committee comments

12.65 The Committee recognises the importance of a regular review of the functioning of the VAD legislation. The Committee notes this would keep the Legislative Assembly abreast of the functioning of the legislation to ensure it reflects the needs of the NT. The Committee considers the 2024 Expert Panel Report's recommendation that the first review occur on the third anniversary after the commencement of VAD legislation, and then every five years is practical.

12.66 The Committee notes there are a range of issues that Territorians considered important to be included in this future review. Many of these issues align with what will be considered in other jurisdictions in the coming years. In this regard, the Committee considers it appropriate that the review of the Act consider the principles

[760] Submission 389.
[761] Meeting with representative of the Australian Christian Lobby, Alice Springs, 21 August 2025.
[762] The Royal Australasian College of Physicians, *Statemen on Voluntary Assisted Dying* (2018), pp. 13-14.
[763] L. Willmott, B. White, C. Haining, 'Review of the Voluntary Assisted Dying Act 2019 (WA)' (2025), *Journal of Law and Medicine* 32(1), p. 160.
[764] L. Willmott, B. White, C. Haining, 'Review of the Voluntary Assisted Dying Act 2019 (WA)' (2025), *Journal of Law and Medicine* 32(1), p. 160.
[765] Submission 203.

set out in the Act (with particular regard to cultural safety and equity of access), eligibility criteria (including excluded conditions), and whether the legislation is operating as intended.

12.67 To align with the majority of other jurisdictions, the report of the review should be tabled in the Legislative Assembly as soon as practicable after finishing the review.

Recommendation 78

The Committee recommends that the legislation should provide that:

a. The Minister must review the operation and effectiveness of the NT's legislation as soon as practicable:

i. three years after the day of its commencement (the first review); and

ii. every five years after the first review of the NT legislation is presented to the Legislative Assembly.

b. The review must include consideration of:

i. the principles set out in the NT legislation;

ii. the eligibility criteria; and

iii. whether the legislation is operating as intended.

c. As soon as practicable after finishing the review, the Minister must table a report about its outcome in the Legislative Assembly.

Contraventions and offences

12.68 Legislative obligations and prohibitions are safeguards to ensure compliance with the VAD process.[766] The 2024 Expert Panel Report provided limited information about the scope of offences and contraventions to be included in the legislation and did not provide a formal recommendation on the topic. However, it noted that the imposition of heavy sanctions for serious criminal offences and appropriately weighted penalties for lesser contraventions would promote compliance with the Act. It also noted that certain conduct may lead to disciplinary breaches under the Health Practitioner National Law.[767]

Approaches in other jurisdictions

12.69 All VAD legislation includes a range of serious criminal offences which may result in penalties, including imprisonment, and less serious offences and contraventions relating to non-compliance with the procedural requirements of the Act. Differentiation is made between offences that any person may commit and offences which only those who are involved in the VAD process may commit.

[766] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 45

[767] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 45

12.70 Examples of serious offences which could apply to any person include unauthorised administration of a VAD Substance,[768] inducing or coercing a person to request VAD,[769] and inducing or coercing a person to self-administer a VAD Substance.[770] Some jurisdictions also make it an offence to induce someone to revoke their request to access VAD, including their Administration Decision.[771] The offence of administering a VAD Substance intending to cause death, knowing that it is not authorised under the Act, can carry a maximum penalty of life imprisonment.[772]

12.71 Examples of other serious offences which apply to persons who participate in the VAD process include knowingly providing false or misleading information,[773] falsifying documents,[774] and unauthorised recording, using or disclosing personal information obtained in the course of exercising a function under the Act.[775]

12.72 Other less serious contraventions relating to non-compliance with the procedural requirements of the Act include failure to submit forms within the timeframe[776] and a Contact Person failing to return the unused VAD substance within the specified timeframe.[777] As noted by the 2024 Expert Panel Report, these offences "are treated as regulatory offences attracting a fine and may also constitute disciplinary breaches which may lead to action for professional misconduct against health practitioners".[778]

Evidence before the Committee

12.73 The Committee received limited evidence on the topic of contraventions and offences.[779] Some stakeholders highlighted the necessity of adding offences as deterrent measures. The Clem Jones Group noted in its submissions that offences and penalties "are instrumental in deterring wrongful actions and should be included in any NT VAD law".[780]

12.74 Very few stakeholders commented on the specific offences that should be included in the legislation. Dying with Dignity Queensland recommended the NT:

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[768] See for example, *Voluntary Assisted Dying Act 2024* (ACT), s 75; *Voluntary Assisted Dying Act 2021* (QLD), s140.
[769] See for example, *Voluntary Assisted Dying Act 2024* (ACT), s 40; *Voluntary Assisted Dying Act 2021* (QLD), s 141.
[770] See for example, *Voluntary Assisted Dying Act 2024* (ACT), s 76; *Voluntary Assisted Dying Act 2024* (QLD), s 142.
[771] See for example, *Voluntary Assisted Dying Act 2024* (ACT), ss 40, 49; *Voluntary Assisted Dying Act 2021* (QLD), s 141.
[772] See for example, *Voluntary Assisted Dying Act 2018* (WA), ss 99, 101; *Voluntary Assisted Dying Act 2017* (Vic), s 84.
[773] See for example, *Voluntary Assisted Dying Act 2022* (NSW), s 123; *Voluntary Assisted Dying Act 2018* (WA), s 102.
[774] See for example, *Voluntary Assisted Dying Act 2017* (Vic), s 87.
[775] See for example, *Voluntary Assisted Dying Act 2022* (NSW), s 126.
[776] See for example, *Voluntary Assisted Dying Act 2018* (WA), s 108.
[777] See for example, *End-of-Life Choices (Voluntary Assisted Dying) Act 2024* (Tas), s 131; *Voluntary Assisted Dying Act 2018* (WA), s 105.
[778] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 45
[779] Submissions 91, 108, 161.
[780] Submission 161.

Replicate Queensland's offence provisions for unauthorised administration, coercion, falsification of documents, misleading the Board, and misuse of substances.[781]

Committee comments

12.75 The Committee proposes to include new offences about non-compliance with the Act in the legislation that are consistent with the Australian model of VAD.

Recommendation 79

The Committee recommends that the legislation should:

a. Create new offences about non-compliance with the legislation.

b. Provide certain offences will apply to 'any person' while other offences will apply to those who have a specified role under the legislation.

c. Provide that serious offences which apply to 'any person' should include:

i. unauthorised administration of a VAD Substance;

ii. inducing a person to request VAD; and

iii. inducing a person to self-administer a VAD Substance.

d. Provide that serious offences which apply to persons who participate in the VAD process should include:

i. knowingly providing false or misleading information about VAD to the Review Board;

ii. knowingly making a false or misleading statement on a document required to be made under the legislation;

iii. falsifying documents; and

iv. recording, using or disclosing personal information obtained in the course of exercising a function under the legislation, unless this is done:

- **for a purpose under the legislation;**
- **with the relevant person's consent; or**
- **as authorised or required by law.**

e. Create offences relating to non-compliance with the procedural requirements of the legislation, including:

i. a health practitioner performing a function under the legislation failing to submit the required forms within the specified timeframe; and

ii. a Contact Person failing to return the unused VAD Substance within the specified timeframe.

[781] Submission 91.

Protections

12.76 The 2024 Report did not make specific recommendations in relation to indemnifying participants in the VAD process but observed these provisions are essential in ensuring the "practical workability" of the VAD legislation.[782]

12.77 Indemnity provisions in VAD legislation protect health practitioners and others from liability (criminal, civil and/or professional) for their participation in the VAD process in accordance with the Act.

Approaches in other jurisdictions

12.78 Jurisdictions across Australia extend protection from liability to VAD practitioners[783] which means they are not liable under a criminal or civil proceeding or under a professional standards/code of conduct where they act in accordance with the legislation. These immunities extend to actions or omissions done in good faith.

12.79 Indemnity provisions in VAD legislation include:

- protections for assisting a person to access VAD or being present when the VAD Substance is administered;[784]
- protections for persons acting in accordance with the Act;[785] and
- protections for medical practitioners who refer persons or seek information.[786]

12.80 There are also protections for healthcare workers (including ambulance workers) for not administering lifesaving care in certain circumstances, [787] including where:

- the person has not requested the administration of life sustaining treatment;[788] and/or
- the healthcare worker believes on reasonable grounds that the person is dying after self-administering or being administered the VAD Substance.[789]

12.81 Legislation in other jurisdictions provides that, to remove any doubt, these protections do not prevent a person from making a notification to an oversight body.[790]

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[782] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024 (*2024), p. 45.
[783] See for example, *Voluntary Assisted Dying Act 2022* (NSW), Part 9; *Voluntary Assisted Dying Act 2021* (Qld), Part 10; *Voluntary Assisted Dying 2021* (SA), Part 8; *Voluntary Assisted Dying 2024* (ACT), Part 9.
[784] See for example, *Voluntary Assisted Dying Act 2022* (NSW), s 130; *Voluntary Assisted Dying Act 2021* (Qld), s 147; *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas), Part 19; *Voluntary Assisted Dying 2017* (Vic), s 79; *Voluntary Assisted Dying 2017* (WA), s 113; *Voluntary Assisted Dying 2021* SA), s 94.
[785] See for example, *Voluntary Assisted Dying Act 2022* (NSW), s 131; *Voluntary Assisted Dying Act 2021* (Qld), s 148; *Voluntary Assisted Dying 2017* (Vic), s 80; *Voluntary Assisted Dying 2017* (WA), s 114.
[786] See, for example, *Voluntary Assisted Dying Act 2022* (NSW), s 132; *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas), s 137.
[787] See for example, *Voluntary Assisted Dying Act 2022* (NSW), s 133; *Voluntary Assisted Dying Act 2021* (Qld), s 148; *Voluntary Assisted Dying 2017* (Vic), s 81; *Voluntary Assisted Dying 2017* (WA), s 115; *Voluntary Assisted Dying 2021* (SA), s 96.
[788] See for example, *Voluntary Assisted Dying 2024*(ACT), s 131(1)(b).
[789] See for example, *Voluntary Assisted Dying 2021* (Qld), s 149(1)(b).
[790] See for example, *Voluntary Assisted Dying 2024* (ACT), s 133.

12.82 The Committee notes that health practitioners are required to hold professional indemnity insurance under the Health Practitioner National Law in accordance with their applicable National Board Standards.

Evidence before the Committee

12.83 The Committee heard about the importance of legal protections for healthcare workers,[791] noting they provide:

- certainty and confidence for those who help a person to access VAD in accordance with legislation;[792] and
- positive perceptions about VAD being justifiable and legitimate by patients, health practitioners, and the public.[793]

12.84 The Committee heard about the complexities of delivering VAD in remote communities and the necessity to ensure legal protections for healthcare workers. During a remote community consultation, the Committee heard that nurses would require protection from liability:

> People get sued. Nurses get sued. As a nurse, you stand alone; that is the reality. …it is your registration, and you have got the right to say yes or no. So you cannot say because I was part of a team I just did what the doctor was saying. Protection for the nurses in that sense…
>
> The problem in remote is the perception that it is a white man's medication, we have come to kill people. So, they will stand up against that nurse, and trust me they can. We are living amongst [Aboriginal people]; we are in the same community, so we need to feel protected when we walk out of here where they do not say there is that nurse that killed my uncle or my auntie.[794]

12.85 Jacqueline Bethel, CEO of Tennant Creek Mob Aboriginal Corporation noted:

> We do not want any of that coming back on doctors or medical staff to put them in a position where they may be sued for making the wrong decision.[795]

12.86 In general, the evidence widely recognised the need for health practitioners, including medical practitioners and nurses, to be provided legal protections. However, some stakeholders identified the need for such protection to extend to other allied health workers. Speech Pathology Australia stated it is important to ensure the legislation explicitly recognises speech pathologists have "the same legal protections [as health practitioners] including immunity from criminal and civil liability and the right to conscientiously object to participation in the VAD process".[796] The organisation stated:

> Speech pathologists must be formally recognised as part of the health professional workforce supporting access to VAD, with equivalent rights, responsibilities and

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[791] Submissions 56, 91, 368; Meeting with staff and residents, Old Timers Aged Care, Alice Springs, 21 August 2025.
[792] B. White et al., 'Does the *Voluntary Assisted Dying Act 2017* (Vic) reflect its stated policy goals?' (2020), UNSW Law Journal 43(2), p. 38.
[793] B. White, C. Haining and L. Willmott, 'How best to regulate voluntary assisted dying: a qualitative study of perceptions of Australian doctors and regulators' (2025), *Medical Law Review* 33, p. 22.
[794] Meeting with Pulkapulkka Kari Flexible Aged Care, Tennant Creek, 27 August 2025.
[795] Meeting with Tennant Creek Mob Aboriginal Corporation, Tennant Creek, 28 August 2025.
[796] Submission 182.

> protections under the Bill. This includes protection from criminal prosecution for actions taken in good faith within the scope of the VAD legislation… These protections should explicitly include immunity from criminal prosecution when engaging in lawful professional conduct related to Voluntary Assisted Dying (VAD)[797]

Committee comments

12.87 The Committee considers that legal protections should apply for people involved in the VAD process. Whilst noting the 2024 Expert Panel Report did not make a specific recommendations on this issue, the Committee notes it is an integral part of the functioning of VAD schemes and is reflected in legislation in all other Australian jurisdictions.

Recommendation 80

The Committee recommends that the legislation should provide that a person will not be criminally, civilly or professionally (as relevant) liable for:

- **a. assisting another person who makes a request to access VAD;**
- **b. being present when another person self-administers or is administered a VAD Substance;**
- **c. acting in accordance with the legislation; or**
- **d. providing information to the Review Board in accordance with the legislation.**

Recommendation 81

The Committee recommends that the legislation should provide that health practitioners will not be criminally, civilly or professionally (as relevant) liable for referring a patient who requests VAD services to another health practitioner.

Recommendation 82

The Committee recommends that the legislation should provide that health practitioners or others who would normally have a duty to administer life sustaining treatment will not be criminally, civilly or professionally (as relevant) liable for refraining from administering life sustaining treatment where:

- **a. they believe on reasonable grounds that the person is dying after administering the VAD Substance; and**
- **b. the person does not request life sustaining treatment.**

Recommendation 83

The Committee recommends that the legislation should provide that nothing in this section prevents a person from making a mandatory or voluntary complaint about a person to any relevant oversight body.

[797] Submission 182.

13 Other considerations

Overview

13.1 The Chapter sets out other matters that should be considered in the drafting, implementation and post-implementation phases of the VAD legislation in the NT.

Miscellaneous provisions in the legislation

13.2 There are a number of minor but important miscellaneous issues typically addressed outside the substantive parts of the VAD legislation.

Approaches in other jurisdictions

13.3 In other jurisdictions, these 'miscellaneous' provisions include, but are not limited to:

- recognising that a technical error on a form, request, notice or documentation, does not invalidate the form, request, notice or documentation or affect any part of the VAD process;[798]
- notifications under the Health Practitioner Regulation National Law;[799]
- empowering the CEO to authorise:
    - an official VAD navigator service;
    - substance suppliers and disposers;
    - a VAD Substance;
    - VAD practitioner requirements;
    - approved information;
    - approved training; and
    - approved forms;[800]
- the scope and purpose of regulations made under the Act;[801] and
- the requirement of a Review Board (or relevant body) to notify practitioners when a form has been received.[802]

Evidence before the Committee

13.4 The Committee was provided with limited evidence on these topics.

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[798] See for example, *Voluntary Assisted Dying Act 2017* (Vic), s 42; *Voluntary Assisted Dying Act 2021* (QLD), s 155.
[799] See for example, *Voluntary Assisted Dying Act 2024* (ACT), s 133(a).
[800] See for example, *Voluntary Assisted Dying Act 2021* (QLD), ss 158-166.
[801] See for example, *Voluntary Assisted Dying Act 2021* (SA), s 130.
[802] See for example, *Voluntary Assisted Dying Act 2022* (NSW), s 171.

Committee comments

13.5 The Committee notes that inclusion of miscellaneous provisions is important to ensure the proposed VAD legislation is comprehensive and functional.

Recommendation 84

The Committee recommends that the legislation should include miscellaneous provisions, including, but not limited to:

a. recognising that a technical error on a form, request, notice or documentation, does not invalidate the form, request, notice or documentation or affect any part of the VAD process;

b. notifications under the Health Practitioner Regulation National Law;

c. empowering the CEO to authorise:

i. an official VAD navigator service;

ii. substance suppliers and disposers;

iii. a VAD Substance;

iv. VAD practitioner requirements;

v. approved information;

vi. approved training; and

vii. approved forms;

d. the scope and purpose of Regulations made under the legislation; and

e. the requirement of the Review Board to notify practitioners when a form has been received.

Implementation timeframe of the legislation

13.6 The 2024 Expert Panel Report recommended VAD legislation should be ready for operational implementation within 18 months of the legislation being enacted. The Expert Panel suggested many aspects of the legislation can be established immediately and, as such, implementation may be possible within a shorter timeframe.

13.7 The Committee supports Recommendation 22 of the 2024 Expert Panel Report.

Approaches in other jurisdictions

13.8 After passing VAD Acts, each jurisdiction has required their VAD schemes to be operational within a certain period. The majority of jurisdictions have provided for an 18-month implementation timeline. This period is intended to enable sufficient time to implement the requirements of the VAD Act, including establishing the necessary services and structures. Drawing on the experience of other Australian jurisdictions, some of the key aims of the implementation period are to:

- establish statewide services to support the delivery of VAD, including the navigator and pharmacy services;

- develop guidelines and training to educate and support healthcare workers;
- design policy to support the safe and compassionate delivery of VAD;
- establish the Review Board to provide system governance and oversight;
- develop an information management system or other processes to facilitate information sharing requirements under the legislation; and
- conduct engagement and consultation with clinical stakeholders and the wider community to ensure that VAD resources and services are fit for purpose and to raise awareness.

Evidence before the Committee

13.9 The Committee received limited feedback on the implementation timeframe for the legislation. In general, the Committee heard support for the 2024 Expert Panel Report's recommendation for an 18-month implementation timeline.[803] CHO of NT Health, Dr Paul Burgess stated:

> I think we have some advantages in being the last jurisdiction in terms of learning from other jurisdictions that have gone before us in terms of implementation timeframes. I think it is feasible. The vision formally was to have the legislation, and implementation could be combined so that the processes could occur in parallel, lockstep. That is one option; the other option is to wait for legislation and then to start the implementation process, but 18 months, given the scale of the startup would require some investment at that time in the 18-month period in terms of setting up systems and training. After that I think it would be fairly smooth sailing.[804]

13.10 One stakeholder recommended the implementation timeframe could be shorter, suggested a 12-month timeframe would be more appropriate and align with the timeframe for the ACT legislation.[805]

Committee comment

13.11 The Committee notes there are a number of services and structures that must be established during the implementation phase of VAD legislation. The Committee considers the 2024 Expert Panel Report's recommendation for an 18-month implementation timeframe is appropriate. The Committee notes this is consistent with other jurisdictions.

Recommendation 85

The Committee recommends that the legislation should be ready for operational implementation within 18 months of the legislation being enacted.

[803] NT Health, Public Hearing, Darwin, 5 August 2025; Australian Medical Association NT, Public Hearing, Darwin, 5 August 2025; Submission 84.
[804] NT Health, Public Hearing, Darwin, 5 August 2025.
[805] Submission 84.

Public education

13.12 Whilst it did not make a formal recommendation, the 2024 Expert Panel Report highlighted the need for public education "not only in terms of ensuring people have the choice of access but also to address fears, concerns and misinformation".[806] The Expert Panel suggested this public information campaign could be led by the NT VAD team, health services or not-for-profit organisations. The 2024 Expert Panel Report also noted VAD services should work with specific groups to ensure information is targeted. These groups included the AMSANT, Dementia Australia, and Council on the Ageing NT.

Approaches in other jurisdictions

13.13 Other jurisdictions have adopted different approaches to public education during the implementation phase of VAD legislation and beyond. The Committee notes other jurisdictions have noted a lack of public awareness about VAD and a need for more resources to ensure people are aware of their end-of-life options.[807] For example, the five year Review of Victoria's VAD legislation found there was a lack of public awareness of VAD. In particular, the review found there is a lack of culturally appropriate guidance for Aboriginal and Torres Strait Islander people, noting this "suggests a potential gap in communication and understanding, leading to confusion or exclusion".[808]

Evidence before the Committee

13.14 Many stakeholders to the Inquiry pointed to the need to raise awareness about VAD before, during and beyond the implementation period.[809] Palliative Care NT highlighted the importance of public education:

> Similarly, the general community need information about pathways to healthcare and other support for people with life limiting illness and conditions. Again, introducing VAD is a cultural shift within the community. Providing appropriate information and support for its introduction and operation is an investment the NT must make for an effective VAD service.[810]

13.15 In remote communities, the Committee heard that people had not had enough time to consider VAD as an end-of-life option and education was needed to enable people to make fully informed decisions.[811] In Ngukurr, a community member stated:

> Put it this way, we are clear that we are not ready to go that line... We are not ready, but we need to have everyone informed so that we know what will come

[806] NT Government, Voluntary Assisted Dying Independent Expert Panel, *Report into Voluntary Assisted Dying in the Northern Territory – Final Report 2024* (2024), p. 85.
[807] WA Department of Health, *Statutory Review – Voluntary Assisted Dying Act 2019*, *Final Report 2024* (2024), p. 3.
[808] Victorian Department of Health, *Review of the Operation of Victoria's Voluntary Assisted Dying Act 2017* (2024), p. 23.
[809] Submissions 5, 6, 25, 35, 36, 51, 66, 125, 153, 161, 166, 167, 257, 300, 389.
[810] Submission 153.
[811] Meetings with representatives of Ngukurr, Numbulwar, Tennant Creek, and Maningrida, August 2025.

> ...A lot of our elders were talking. It really is for us that we need more information and we need to study that more. We want to support it, but we need more.[812]

13.16 Lesley Woolf, Executive Health Manager of Mala'la Health Services Aboriginal Corporation in Maningrida highlighted the importance of education and time to support a shift to speaking about VAD in communities:

> It took some years before advance health directives were even discussed. It is like an evolution, I guess. Because it is not something that has ever been considered it has not been discussed. I hear on the radio people talk about voluntary assisted dying, et cetera, but it is not something that has ever been discussed, that I am aware of, in the community. It may have been discussed amongst some of the balanda people, or non Aboriginal people. It is certainly not something that is discussed... But I guess over the years then it may be that it is a discussion that, say, a doctor has with a patient or with the family. I do not think that will happen next week if it was legislated next week. That will not happen; it will take time before it even becomes part of the conversation.[813]

13.17 Many stakeholders highlighted the need for public education to be clear and easy to read to ensure it is accessible for all Territorians.[814] Some stakeholders highlighted the need to ensure public education is accessible for people with disabilities, including the use of different means of communication.[815] For many stakeholders, it was important that resources are multilingual and appropriate translators and interpreters are involved in the education process.[816] The Committee heard about the need for interpreters to safeguard against the dangers of misinformation and disinformation regarding VAD. Barkly Regional Council Mayor, Sid Vashist stated:

> ...in a way that interpretation and the language where people have a better understanding in how to go about this, because there is misinformation and disinformation and this needs to be tackled. To tackle that you will need the support of Aboriginal interpreter services. When you are going out in the communities, the communities, once they have a better understanding, is something I think community will potentially get behind, but they need to be consulted on the ground.[817]

13.18 Some interstate stakeholders pointed to the experiences of other jurisdictions, particularly highlighting the findings in Victoria, WA and Queensland.[818] The Clem Jones Group stated:

> Wider and deeper public knowledge of voluntary assisted dying and how a VAD scheme works can, in our opinion, help it work more effectively and safely as people would be more aware of their rights and obligations under the VAD law and regulations.
>
> We suggest that the NT learn from the Victorian and WA experiences – which may well be repeated in other jurisdictions' reviews as they occur – and pre-empt any similar problems by conducting a major Territory-wide public information campaign in association with the development of training and accreditation systems prior to the start of any VAD scheme.

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[812] Meeting with St Matthew's Anglican Church, Ngukurr, 6 August 2025.
[813] Meeting with community representatives of Maningrida, Darwin, 25 August 2025.
[814] Submission 25.
[815] Submission 51.
[816] Submissions 25, 51, 66, 125, 389.
[817] Meeting with Barkly Regional Council and Tennant Creek Local Authority, Tennant Creek, 27 August 2025.
[818] Submissions 125, 161, 257.

> Such an effort should include specialised and targeted information campaigns for Aboriginal and Torres Strait Islander communities... Victoria's mandated five-year review of its VAD scheme mentioned above included a stand-alone independent review conducted by a specialist Aboriginal-owned research and evaluation firm, Karabena Consulting, to ensure culturally sensitive consultations about the operation of the state's VAD Act took place with Aboriginal elders and community members.
>
> In summary, the Karabena Consulting review found low awareness of VAD and limited tailored information and support for Aboriginal and Torres Strait Islander people and people from multicultural communities. These findings reinforce the need for tailored information programs...[819]

Committee comment

13.19 The Committee considers it important that all Territorians are aware of the end-of-life choices available to them and misinformation and disinformation should be discouraged. This view is consistent with the 2024 Expert Panel Report. Public information should be clear, accessible and available in multiple languages. In light of the evidence presented throughout the Inquiry and the experiences of other jurisdictions, the Committee considers this should include culturally safe information for Aboriginal and Torres Strait Islander people.

Recommendation 86

The Committee recommends that the Government implement a culturally safe and accessible public information campaign during and after the implementation phase of the VAD legislation.

Regulation of VAD beyond the legislation

13.20 If VAD is legalised in the NT, additional regulation and policy will need to be established to support a safe and accessible VAD system. This section briefly discusses some of these matters including Regulations, CEO requirements, medication protocols and professional guidance and training.

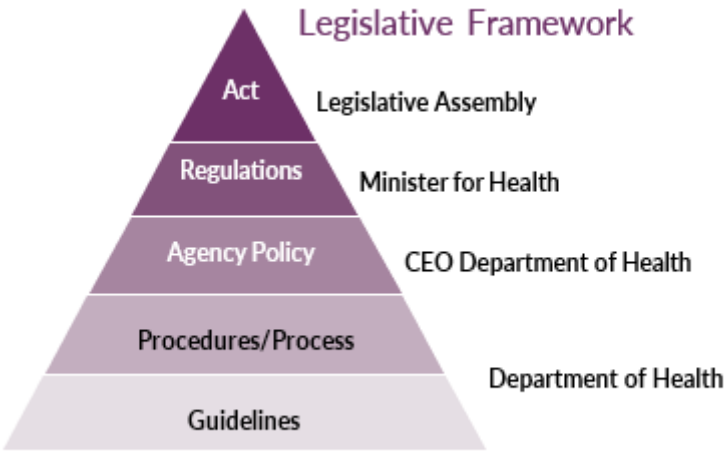
13.21 The NT may consider establishing the following additional regulation and policy to support the administration of the VAD system:

- Regulations;
- CEO requirements;
- Medication protocols; and
- Professional guidelines and training.

13.22 The 2024 Expert Panel Report did not make any recommendations specifically in relation to making Regulations, policy or guidelines. However, they were envisaged in the legislative model proposed (see Figure 19 below).

[819] Submission 161.

Figure 19: Proposed NT VAD legislative framework[820]



13.23 The 2024 Expert Panel Report did not make any specific recommendations in relation to the content of Regulations but suggested they might include the assessment criteria for residency eligibility exemptions.[821]

13.24 The 2024 Expert Panel Report noted clinical guidelines are "important to ensuring health care professionals have a comprehensive understanding of VAD and their responsibilities under the legislative framework".[822] The Expert Panel suggested clinical guidelines should be made by the CEO of NT Health and in collaboration with Aboriginal organisations. Matters to be covered included:

- delineating roles and responsibilities in VAD;
- clarifying the process for requesting VAD;
- outlining eligibility criteria and assessment procedures;
- detailing the prescription, supply, and administration of VAD substance; and
- outlining the roles and responsibilities of the proposed pharmacy and care navigator services and providing their contact details.

Approaches in other jurisdictions

Regulations

13.25 Regulations exist in Tasmania, SA, Queensland, Victoria and the ACT. While the scope of the Regulations varies significantly between jurisdictions, some key areas relevant to the proposed NT model include:

- the prescribed forms to be used in the VAD process;
- accreditation requirements for interpreters;

[820] NT Government, *Voluntary Assisted Dying Independent Expert Panel – final report* (2024), p. 15.
[821] NT Government, *Voluntary Assisted Dying Independent Expert Panel – final report* (2024), p. 56.
[822] NT Government, *Voluntary Assisted Dying Independent Expert Panel – final report* (2024), p. 43.

- secure storage specifications for the VAD Substance;
- requirements for prescribing the VAD Substance;
- labelling requirements for the VAD Substance;
- requirements for disposal of the VAD Substance;
- the relevant persons involved in providing or supporting the provision of health or care services for the purposes of conscientious objection provisions;
- functions of the Review Board to record and keep information; and/or
- any other processes to support the safe and accessible operation of the VAD system.

CEO requirements

13.26 To support the operation of the NT VAD legislation, and pursuant to proposed specific provisions, the CEO may approve additional requirements in relation to:

- information that must be provided to a person making a First Request;
- prescribed forms that must be submitted to the Review Board;
- additional eligibility requirements for Coordinating, Consulting or Administering Practitioners;
- mandatory training to be undertaken by participating practitioners;
- the type of substance that may be used for the purpose of causing the person's death in accordance with the legislation;
- authorised suppliers and disposers of the VAD Substance; and
- approving a service to be an official VAD Care Navigator Service for the purposes of the NT VAD legislation.

Medication protocols

13.27 All Australian jurisdictions have established a centralised pharmacy service which is the only authorised supplier of VAD medication. To support the safe and consistent delivery of VAD, each jurisdiction has developed a medication protocol to which pharmacists and VAD practitioners must strictly adhere. The standardisation provided by these medication protocols provides additional control and safety over the VAD process.

Professional guidelines and training

13.28 To support healthcare workers and VAD practitioners, comprehensive guidelines have been developed in all Australian jurisdictions. These guidelines typically cover the regulatory framework, the steps in the VAD process, the roles and responsibilities of healthcare workers (with a focus on VAD practitioners), the functions of the Review Board, the role of statewide services, and general clinical guidance.

13.29 The Australian model of VAD includes a requirement that participating practitioners (Coordinating, Consulting and Administering Practitioners) must undertake

mandatory training prior to providing VAD; this requirement is also included in the Committee's recommendations. This training is typically delivered online via a series of eLearning modules that situate VAD within the end-of-life context and educate practitioners about their roles and responsibilities under the legislation, the eligibility criteria and process to access VAD, and the broad regulatory framework. While the training focuses on the legal process, it also provides some clinical guidance and resources. To successfully complete the training and demonstrate competency, practitioners are required to pass an assessment.

13.30 While VAD practitioners play a key role in the provision of VAD, other healthcare workers also play an important role supporting patients accessing VAD, and practitioners providing VAD. Many Australian jurisdictions have developed short online training modules and resources to educate healthcare workers about the VAD process, and their roles and responsibilities.

Evidence before the Committee

13.31 The Committee received limited evidence on this issue.

13.32 Primarily stakeholders to the Inquiry focused on the need to develop professional guidelines for healthcare workers. The Committee heard about the need for specific guidance for healthcare workers, including:

- Pharmacists;[823]
- Paramedics and ambulance workers;[824] and
- Speech pathologists.[825]

13.33 The Committee heard of the need to embed cultural safety principles in Regulations and guidelines, in addition to the primary legislation. Michael Coughlan, Executive Manager - First Nations Programs at ARRCS stated:

> In addition, any VAD guidelines and regulations should contain provisions for culturally appropriate Aboriginal and Torres Strait Islander care plans, including return to country support.[826]

13.34 Stakeholders suggested there should be consultation on Regulations and policy. NT Health pointed to the importance of developing Regulations and policy through continued consultation:

> A careful calibration of legislative structures and operational regulations and policies is required to permit the development of a VAD program to best suit the needs of the NT. We suggest that continued consultation with NT Health subject matter experts will be required to achieve this objective.[827]

13.35 The Australian Lawyers Alliance (ALA) similarly stated:

> ALA submits that any regulations and guidelines concerning Voluntary Assisted

[823] Submission 167.
[824] Submission 166.
[825] Submission 182.
[826] Submission 381.
[827] Submission 369.

> Dying must be made public for stakeholder consultation, in conjunction with consultation on future proposed legislation, *before* the Northern Territory's Voluntary Assisted Dying scheme is finalised.[828]

13.36 The Clem Jones Group suggested that Regulations should also be subject to regular reviews to provide appropriate opportunities for public feedback:

> We consider that regular reviews, preferably parliamentary reviews enabling public input, are essential to ensure Territorians are given opportunities to have an ongoing voice in the operation of a VAD scheme and its overarching VAD law and regulations.[829]

Committee comments

13.37 To support the operation of the NT VAD legislation, and in line with proposed specific provisions recommended throughout this Report, the Committee considers that the legislation should be accompanied by a range of other regulatory instruments. These include Regulations, CEO requirements, medication protocols, professional guidelines and training.

13.38 The Committee considers it important that these instruments are developed in consultation with Territorians to ensure they meet their unique needs. The Committee highlights that all policy and legislation should reflect the principles of cultural safety and be responsive to the evolving model of care for the VAD legislation

[828] Submission 157.
[829] Submission 161.

Appendix 1: Submissions received

Submission No. 1 - Raemyn Carrick

Submission No. 2 - Peter Shapcott

Submission No. 3 - Anna Philip

Submission No. 4 - Andrew Roberts

Submission No. 5 - Professor Ben White and Professor Lindy Willmott

Submission No. 6 - Darryl Butler

Submission No. 7 - Chris Blackham-Davison

Submission No. 8 - Judith Igusti

Submission No. 9 - Don Murfett

Submission No. 10 - Georgia Knight

Submission No. 11 - Sharon Cramp-Oliver

Submission No. 12 - Ann Stephens

Submission No. 13 - Rev. Steve Walker

Submission No. 14 - Andrew Kearney

Submission No. 15 - Janette Carter

Submission No. 16 - Brent Payne

Submission No. 17 - Lori Martin

Submission No. 18 - Kristan Slack

Submission No. 19 - Canberra Declaration

Submission No. 20 - Chantal Heazlewood

Submission No. 21 - Sonja Pastor

Submission No. 22 - Urapuntja Health Service Aboriginal Corporation

Submission No. 23 - S Stephens

Submission No. 24 - Dr Jennifer Jobst

Submission No. 25 - Mental Health Association of Central Australia

Submission No. 26 - Bruce Toohill

Submission No. 27 - Doctors for Assisted Dying Choice

Submission No. 28 - Gavin Perry

Submission No. 29 - Penelope Stevens

Submission No. 30 - Dave Ives

Submission No. 31 - John Marshall

Submission No. 32 - Poh Lim

Submission No. 33 - Christine Mansfield

Submission No. 34 - Lorraine Davies

Submission No. 35 - Marshall Perron

Submission No. 36 - Wayne Wood

Submission No. 37 - Exit International

Submission No. 38 - Paul Lassemillante

Submission No. 39 - Kylee Neilson

Submission No. 40 - John Derrington

Submission No. 41 - Mary Ahearn

Submission No. 42 - Coralie Richmond

Submission No. 43 - Debra Chamings

Submission No. 44 - Joy Kelly

Submission No. 45 - Kirby Dixon

Submission No. 46 - Dave and Doreen Dyer

Submission No. 47 - Margaret and David Blanch

Submission No. 48 - Reverend Sid Rogers

Submission No. 49 - Steven O'Grady

Submission No. 50 - Nikki Cannon

Submission No. 51 - Kevin and Aurora Quinn

Submission No. 52 - Richard Rehrmann

Submission No. 53 - Phyliss Wagner

Submission No. 54 - Chris Devonport

Submission No. 55 - Shirley Hendy

Submission No. 56 - Hon Michael Gaffney MLC

Submission No. 57 - Claire Watson

Submission No. 58 - Robyn Maggs

Submission No. 59 - Sue Gorringe-Lupton

Submission No. 60 - Cynthia W

Submission No. 61 - Elaine Ellard

Submission No. 62 - Ian E

Submission No. 63 - Jeffry Cole

Submission No. 64 - Prudence Birdling

Submission No. 65 - Carol Doyle

Submission No. 66 - Rebecca Trimble

Submission No. 67 - Gerry Wood

Submission No. 68 - Geoffrey Williams

Submission No. 69 - Dr Craig Glasby

Submission No. 70 - Elizabeth Cohen

Submission No. 71 - Christians Supporting Choice for Voluntary Assisted Dying

Submission No. 72 - LeAnn Angel

Submission No. 73 - Lynette Kelly

Submission No. 74 - Suzanne James

Submission No. 75 - Hugh Bradley AM and Sue Bradley AM

Submission No. 76 - Dr Ray Ingamells

Submission No. 77 - Linda Reynolds

Submission No. 78 - Andrew Reynolds

Submission No. 79 - Calvin O

Submission No. 80 - Sally Gearin

Submission No. 81 - David Strickland

Submission No. 82 - Maggie Crewes

Submission No. 83 - Northern Territory Voluntary Euthanasia Society

Submission No. 84 - Emeritus Professor Michael Charles Quinlan

Submission No. 85 - Rebecca T

Submission No. 86 - Caroline Auld

Submission No. 87 - Pastor Malcolm Auld - Ilparpa Fellowship

Submission No. 88 - Anthony Willis

Submission No. 89 - Kristine Frances Smith

Submission No. 90 - Australian Care Alliance

Submission No. 91 - Dying With Dignity Queensland

Submission No. 92 - Ben Pfeiffer

Submission No. 93 - Darryl Hill

Submission No. 94 - Royelene Hill

Submission No. 95 - Caroline Cavanagh

Submission No. 96 - Alan Corbett

Submission No. 97 - Catholic Diocese of Darwin

Submission No. 98 - FamilyVoice Australia

Submission No. 99 - David Taylor

Submission No. 100 – Name withheld on request

Submission No. 101 - Dying with Dignity ACT

Submission No. 102 - Chris Purser

Submission No. 103 - Rebekah Matson

Submission No. 104 - Norma Jamieson

Submission No. 105 - Mikaela Rate

Submission No. 106 - Dementia Australia

Submission No. 107 - Name withheld on request

Submission No. 108 - Margaret Warburton

Submission No. 109 - Palliative Care Northern Territory Inc

Submission No. 110 - Robert Batey AM

Submission No. 111 - Brian Radunz

Submission No. 112 - Bethany Seden

Submission No. 113 - Stephen Lewin

Submission No. 114 - Ann David

Submission No. 115 - Mark Herron

Submission No. 116 - Rosemary Boland

Submission No. 117 - Dawyte Hart-O'Neill

Submission No. 118 - Jane Giliam

Submission No. 119 - Owen Hancock

Submission No. 120 - Sam G

Submission No. 121 - Christine Doidge

Submission No. 122 - M Byrne

Submission No. 123 - Kenneth Glasgow

Submission No. 124 - Brett Midena

Submission No. 125 - Dying With Dignity Victoria

Submission No. 126 - William Dunlop

Submission No. 127 - Sam Wilson

Submission No. 128 - Michelle Gibson

Submission No. 129 - Lyndon 'Spud' Thomas

Submission No. 130 - Christopher Tangey

Submission No. 131 - Kathryn Bannister

Submission No. 132 - Voluntary Assisted Dying Review Board of South Australia

Submission No. 133 - Gillian Abraham

Submission No. 134 - End of Life Choice Society NZ

Submission No. 135 - Anne Spry

Submission No. 136 - Voluntary Assisted Dying South Australia

Submission No. 137 - Gabrielle Brown

Submission No. 138 - Ciara O'Brien

Submission No. 139 - Bruce Lindsay

Submission No. 140 - Stuart Burris

Submission No. 141 - Ana Ninneman

Submission No. 142 - Paul Traeger

Submission No. 143 - Name withheld on request

Submission No. 144 - Zoe Knight

Submission No. 145 - Loretta Muratore

Submission No. 146 - Michael Ninneman

Submission No. 147 - Dr Megan Pickering

Submission No. 148 - Dr Joanne Wright

Submission No. 149 - Hon Daryl Manzie AM

Submission No. 150 - Penny La Sette

Submission No. 151 - Sarah Doecke

Submission No. 152 - Sonia Van der Aa

Submission No. 153 - Palliative Care Australia

Submission No. 154 - Hon Robert Clark

Submission No. 155 - Kimberley Robson

Submission No. 156 - Dr Tim Coyle

Submission No. 157 - Australian Lawyers Alliance

Submission No. 158 - Reverend Kenneth Devereux

Submission No. 159 - The Royal Australian and New Zealand College of Psychiatrists

Submission No. 160 - Beverley Witby

Submission No. 161 - The Clem Jones Group

Submission No. 162 - Dianne Lange

Submission No. 163 - Dying with Dignity Tasmania

Submission No. 164 - Dr David Moore

Submission No. 165 - Roger Clifton

Submission No. 166 - St John NT

Submission No. 167 - The Pharmacy Guild of Australia NT Branch

Submission No. 168 - Australian Psychological Society

Submission No. 169 - Jenny Holland

Submission No. 170 - HammondCare

Submission No. 171 - The Royal Australasian College of Physicians

Submission No. 172 - Voluntary Assisted Dying Board Western Australia

Submission No. 173 - Denyse Bainbridge

Submission No. 174 - The Right to Life Australia

Submission No. 175 - Glory City Church Darwin

Submission No. 176 - Janette Crowhurst

Submission No. 177 - Max Broadway

Submission No. 178 - Beverley Young

Submission No. 179 - Heads of Department - Alice Springs Hospital

Submission No. 180 - Tom Majetic

Submission No. 181 - Dr Fiona Douglas

Submission No. 182 - Speech Pathology Australia

Submission No. 183 - Kevin Hubble

Submission No. 187 - Graeme Tosh

Submission No. 188 - Roena McKeown

Submission No. 189 - Warren McKeown

Submission No. 190 - Marione Gordon

Submission No. 191 - David Hibert

Submission No. 192 - Christine Huttley

Submission No. 193 - Heather Saxty

Submission No. 194 - Eli Webber

Submission No. 195 - Ashley White

Submission No. 196 - Kate Kunzelmann

Submission No. 197 - Desmond Gellert

Submission No. 198 - Ben Matson

Submission No. 199 - Fiona Roy

Submission No. 200 - Joshua Lawless

Submission No. 201 - Robert Ovens

Submission No. 202 - Marisa Fontes

Submission No. 203 - Go Gentle Australia

Submission No. 204 - Michael and Mary Stansbie

Submission No. 205 - Name withheld on request

Submission No. 206 - Nicole Waters

Submission No. 208 - Northern Territory Public Guardian and Trustee

Submission No. 209 - Name withheld on request

Submission No. 210 - Elijah Matson

Submission No. 212 - Margaret Opie

Submission No. 214 - Freedom for Faith

Submission No. 215 - Gary Parker

Submission No. 216 - Sharon Curtis

Submission No. 217 - John Huigen

Submission No. 218 - Joyce McNiven

Submission No. 219 - David and Joelle Wrotniak

Submission No. 220 - Phil Browne

Submission No. 221 - Brian Williamson

Submission No. 222 – Not for publication

Submission No. 223 - Greg Sobey

Submission No. 224 - Winston Newman

Submission No. 225 - Name withheld on request

Submission No. 226 - Philip Pocock

Submission No. 227 - Joshua Kuswadi

Submission No. 228 - Peter Barnard

Submission No. 229 - Bronwen Foreman

Submission No. 230 - Nyaruon Puok

Submission No. 231 - Victoria Vildzius

Submission No. 232 - Name withheld on request

Submission No. 233 - Anna Wierzbicka

Submission No. 234 - Pam Utting

Submission No. 235 - John Martin

Submission No. 236 - Name withheld on request

Submission No. 237 - Name withheld on request

Submission No. 238 - Name withheld on request

Submission No. 239 - Betty Hedgecoe

Submission No. 240 - Rob Clements

Submission No. 241 - Allan McEwan

Submission No. 242 - David Fishers

Submission No. 243 - Leslie Beissel

Submission No. 244 - Sarah Bayman

Submission No. 245 - Name withheld on request

Submission No. 246 - Jon Adams

Submission No. 247 - Name withheld on request

Submission No. 248 - Name withheld on request

Submission No. 249 - Malcolm Caldwell

Submission No. 250 - Caroline Joswig

Submission No. 251 - Name withheld on request

Submission No. 252 - Annie Broadway

Submission No. 253 - Corrine Phillips

Submission No. 254 - Barry and Anne James

Submission No. 255 – Not for publication

Submission No. 256 - Gracebel Llorente

Submission No. 257 - Sheila Sim

Submission No. 258 - Tim Cowen

Submission No. 259 - Brian W

Submission No. 260 - David Reilly

Submission No. 261 - Lee-Ann Collier

Submission No. 262 - Ian Brearley

Submission No. 263 - Tonic Jeche

Submission No. 264 - Ami K

Submission No. 265 - Graham Stitz

Submission No. 266 - Meagan Lay

Submission No. 267 - Sheela Joseph

Submission No. 268 - Alenira Willis

Submission No. 269 - Sylvia Kendall

Submission No. 270 - Alexis Moreno de Oliveira Ribeiro

Submission No. 271 - Netani T

Submission No. 272 - Jeremy Fox

Submission No. 273 - Kimberley Brown

Submission No. 274 - Susan Sarantos

Submission No. 275 - Lance Alan

Submission No. 276 - Paul Johnson

Submission No. 277 – Not for publication

Submission No. 278 - Shannon Manning

Submission No. 280 - Alison Nawirridj

Submission No. 282 - Joycelyn Searle

Submission No. 283 - Sandra Adamson

Submission No. 284 - Hayden Blair

Submission No. 285 - Jessica Auld

Submission No. 286 - Samuel Auld

Submission No. 288 - Tom Bird

Submission No. 289 - Philip Manning

Submission No. 291 - Name withheld on request

Submission No. 293 - Sajiv Cherian

Submission No. 294 - Name withheld on request

Submission No. 295 - Name withheld on request

Submission No. 296 - Don Berman

Submission No. 297 - Rowena Kalikajaros

Submission No. 300 - Central Australian Aboriginal Congress

Submission No. 301 - Margot Tong

Submission No. 302 - Lynette Bigg

Submission No. 303 - Catherine Stedman

Submission No. 304 - Stephen Ashford

Submission No. 305 - Rita Zuccher

Submission No. 306 - Chris Bigg

Submission No. 307 - Jennifer Bauer

Submission No. 308 - DIGNITAS - To live with dignity - To die with dignity

Submission No. 309 - Philip Nippress

Submission No. 310 - Sascha Gibson

Submission No. 311 - Claire Cowen

Submission No. 312 - Kim Ninneman

Submission No. 313 - Mary Redmond

Submission No. 314 - Leonard Redmond

Submission No. 315 - Alice Springs church of Christ

Submission No. 316 - Jukka Rammukainen

Submission No. 317 - Ken and Lesley Hansen

Submission No. 318 - Katy Spakman

Submission No. 319 - Dying With Dignity Western Australia

Submission No. 320 - Lutheran Church of Australia SA-NT

Submission No. 321 - Dying With Dignity New South Wales

Submission No. 322 - Daniel Spakman

Submission No. 323 - Patricia Thatcher

Submission No. 324 - Eileen Hall

Submission No. 325a - Rebecca Muller

Submission No. 326 - Nathan Hine

Submission No. 328 - Lorna Manning

Submission No. 329 - Dr Michael Tong

Submission No. 330 - Peter Manning

Submission No. 331 - Anna Huigen

Submission No. 332 - Rhonda Muller

Submission No. 333 - Pro-Life Victoria

Submission No. 334 - Australian Christian Lobby

Submission No. 335 - Kristy Howard

Submission No. 336 - Voluntary Assisted Dying Australia and New Zealand

Submission No. 363 - Iain Radvan

Submission No. 364 - Dr Susan Colen

Submission No. 365 - Barefoot Ministries Australia

Submission No. 366 - Zion Matson

Submission No. 367 - Anglican Diocese of the Northern Territory

Submission No. 368 - Australian Medical Association Northern Territory

Submission No. 369 - NT Health - Department of Health

Submission No. 372 - Christina Young

Submission No. 373 - Christina Auld

Submission No. 374 - Yvonne Pratt

Submission No. 376 - Justin Tutty

Submission No. 377 - Jocelyn Hall, Anyse Horman, Jeanette Wiley, Lynn Robson, Sheila Sim

Submission No. 378 - Professor Kerstin Braun

Submission No. 380 - Joshua Howard

Submission No. 381 - Michael Coughlan - Australian Regional and Remote Community Service

Submission No. 382 - Carolyn Marriott

Submission No. 383 - Doug Warfe

Submission No. 384 - Grief Australia

Submission No. 385 - Grusha Leeman

Submission No. 387 - Naomi Hailstone

Submission No. 388 - Henry Gray OAM

Submission No. 389 - National Seniors Australia

Submission No. 390 - Angelique and Karl Tester

Submission No. 391 - L Harrison

Submission No. 392 - Jim Dominguez CBE AM

Submission No. 393 - Andrea Adams

Submission No. 394 - Suanne Tikoft

Submission No. 395 - Miriam Wallace

Submission No. 396 - Catherine Holdcroft

Submission No. 397 - Women's Forum Australia

Submission No. 398 - Jennifer Howard

Submission No. 399 - Nikki Bennett

Submission No. 400 - Lisa Nunn

Submission No. 401 - Umberto Villa

Submission No. 402 - Pharmaceutical Society of Australia

Submission No. 403 - Aboriginal Medical Services Alliance Northern Territory

Proforma submission A (8 submissions)

Proforma Submission B (2 submissions)

Proforma Submission C (2 submissions)

Proforma Submission D (3 submissions)

Proforma Submission E (26 submissions)

Proforma Submission F (2 submissions)

Appendix 2: Remote consultation report

Darwin – 5 August 2025

The Committee held a public hearing in Darwin on Tuesday, 5 August 2025. Witnesses attended in-person and via Microsoft Teams.

NT Health

The Committee heard from the following witnesses:

- Mr Chris Hosking, Chief Executive Officer;
- Dr Paul Burgess, Acting Chief Health Officer;
- Dr Jeremy Chin, Chief Medical Officer; and
- Dr Kane Vellar, Consultant Psychiatrist, Palliative Care Consultant, and former member of the VAD Independent Expert Panel.

Aboriginal Medical Services Alliance NT

The Committee heard from the following witnesses:

- Dr John Paterson, Chief Executive Officer; and
- Ms Tessa Snowdon, Senior Policy Manager (via Microsoft Teams).

Australian Medical Association NT

The Committee heard from Dr John Zorbas, President of the Australian Medical Association NT.

- Individual Witnesses

The Committee heard from individuals with lived experience of VAD:

- Ms Judy Dent; and
- Mr Wayne Wood.

Ngukurr – 6 August 2025

The Committee travelled to Ngukurr on 6 August 2025 and met with a range of stakeholders. The Committee was assisted by an interpreter, Melissa Wurramarrba, from AIS to facilitate discussions in Kriol.

St Matthews Anglican Church

The Committee met with representatives from St Matthew's Anglican Church, including:

- Reverends Majorie and William Hall, Deacons-in-Charge;
- Reverend Craig Rogers, Deacon; and
- 25 parishioners.

Community Drop-In Session

The Committee held a community drop-in session at the Roper Gulf Regional Council offices in Ngukurr. The Committee met with four individual community members, including Margaret George, Roberta Abajee, and Devita.

Roper Gulf Regional Council

Finally, the Committee met with representatives from Roper Gulf Regional Council, including:

- Cristie Greer, Programs Manager, Aged Care Services (via Microsoft Teams);
- Nikole Giles-Dickinson, Clinical Aged Care Nurse (Rural and Remote) (via Microsoft Teams); and
- Hyeran Kim (Linda), Aged Care and Disability Coordinator (Ngukurr).

Borroloola – 7 August 2025

The Committee travelled to Borroloola on 7 August 2025 and met with a range of stakeholders. The Committee was assisted by an AIS interpreter, Bernadette Nethercott.

Mabunji Aboriginal Resource Indigenous Corporation

The Committee met with representatives from Mabunji Aboriginal Resource Indigenous Corporation, including:

- Brian Hume, Deputy Chairperson;
- Nikita Baker, Executive Assistant;
- Shirley Simon, Director, Mumathumburu Homeland;
- Christine Anderson, Manager, Malandari Aged Care Centre; and
- Deanna Laney, staff. Malandari Aged Care Centre.

Malandari Aged Care Centre

The Committee had a site visit at the Malandari Aged Care Facility, which provides aged care and palliative care to the community.

Borroloola Local Authority

The Committee met with the Borroloola Local Authority, including Local Authority Members:

- Councillor Samuel Evans, Local Authority;
- Donald Garner, Local Authority;
- Trish Elmy, Local Authority;
- Mike Longton, Local Authority;
- David Hurst, Chief Executive Officer, Roper Gulf Regional Council;

- Cindy Haddow, General Manager Corporate Services and Sustainability, Roper Gulf Regional Council;
- Luke Haddow, General Manager Infrastructure Services and Planning, Roper Gulf Regional Council;
- Cristian Coman, Manager Corporate Compliance, Roper Gulf Regional Council;
- Casey Hucks, Council Services Manager, Roper Gulf Regional Council;
- Bhumika Adhikari, Governance Engagement Coordinator, Roper Gulf Regional Council (via Microsoft Teams);
- Daniele Piga, Governance Coordinator, Roper Gulf Regional Council;
- Kerry Lane, Northern Territory Police Force;
- Katrina Cooper, Northern Territory Police Force; and
- Surinder Chriton, Department of Housing, Local Government and Community Development (via Microsoft Teams).

Barunga – 12 August 2025

The Committee travelled to Barunga on 12 August 2025 and held an open forum for community consultation. The Committee was assisted by Roper Gulf Regional Council and an AIS interpreter, Lyn Tindle, to facilitate discussions in Kriol. The Committee met with:

- Nell Brown, Margaret Coleman, Jocelyn McCartney, and Erna Miller, Barunga Elders and Traditional Owners;
- Alison Andrews, Registered Aboriginal Health Practitioner, Sunrise Health Services Aboriginal Corporation; and
- Delma McCarthy, Media Officer, Top End Aboriginal Bush Broadcasting Association.

Wurrumiyanga – 18 August 2025

On 18 August 2025, the Committee held a private briefing via phone with representatives of Tarntipi Homelands Aboriginal Corporation. The Committee met with the following individuals:

- Teddy Portaminni, Chairperson;
- Michael Massingham, Director;
- Teresia Portaminni, Director;
- Nelsina Portaminni, Director;
- Baptista Portaminni, Director;
- Charlotte Portaminni, Director;
- Edwina Portaminni, Director;
- Georgina Portaminni, Director;
- Therese Portaminni, Director;
- Nathan Richardson, Member;
- Pedro Lorenzo, Member; and
- Melanie Schofield, External consultant.

Gunbalanya – 19 August 2025

The Committee travelled to Gunbalanya on 19 August 2025. The Committee met with the Gunbalanya School Board representatives, including the following individuals:

- Kerry Manakgu, Chair Gunbalanya Independent Public School Board;
- Hagar Nadjamerrek, Board member;
- Ursala Badari, Board member;
- Raylene Gellar, Board member;
- Roberta Carlton, Board member;
- Christine Alengale, Board member;
- Rosie Bunker, Board member;
- Esther Djayhgurrnga, Co-Principal;
- Sue Trimble, Co-Principal;
- Joe Brown, Director Community Engagement, NT Department of Education; and
- Suzie Peckham, Senior Community Engagement Advisor, NT Department of Education.

Papunya – 20 August 2025

The Committee travelled to Papunya on 20 August 2025. The Committee's visit was facilitated by Ngurratjuta/Pmara Ntjarra Aboriginal Corporation. Discussions were held in English and Luritja/Pintupi, and were assisted by Cultural Connector, Alison Anderson. The Committee held a community forum with 60 individuals, including:

- Deanne Major;
- Rosita Jugadai;
- Isobel Gorey;
- Isobel Major;
- Candy Nakamarra;
- Josephine Minor;
- Gebrielle Bennett;
- Minnie Nelson;
- Carita Nelson;
- Charlotte Roberts;
- Kael Raggett;
- Puuni Brown;
- Tammy Kalion;
- Janie Karpa;
- Florence Brown;
- Shelia Major;
- Tallisa Kantawarra;
- Mary Nungabor;
- Corama Raggett;
- Jill Kantawara;
- Priscilla Brown;
- Emily Putungka;
- Emma Boughton;
- Shemena Roger;
- Karen McDonald;
- Hita McDonald;
- Vanessa Brumby;
- Janet Tjitayi;
- Roslyn Dixon;
- Ada Andy;
- Garrard Anderson;
- Gerard Pepperill;
- Graham Paulson;
- Dennis Minor;

- Standley Roberts;
- Bruce Inkamala;
- Morris Roberts;
- Clayton Minor;
- Ashley Robertson;
- Tobias Raggett;
- Adrian Stockman;
- Rusty Campbell;
- Dermott Cook;
- Glavin Jack;
- Betty Brown;
- Punata Stockman;
- Robert Minor;
- Travis McDonald;
- Joseph Lane;
- Makinti Robertson;
- Cassandra Minor;
- Una Ratara;
- Taralyn Major;
- Denilee Spencer;
- Dennis Nelson;
- Desmond Phillipus;
- Nellie Tjahjiri;
- Dorathea Nelson; and
- Felicia Inkamada.

Alice Springs – 21 August 2025

The Committee travelled to Alice Springs on 21 August 2025 and met with a range of stakeholders.

Alice Springs Hospital

The Committee visited Alice Springs Hospital. The Committee met with staff from the Aboriginal Engagement and Strategy Unit and the Palliative Care Team, including:

- Patrick Torres, Aboriginal Cultural Coordinator;
- Curtis Lane, Aboriginal Liaison Officer;
- Linda Bray, Aboriginal Liaison Officer;
- Dr Penny Stewart, Aboriginal Engagement and Strategy Unit Department Head;
- Freo Miegel, NCN COM Palliative Care;
- Sharon Clark, CNC Palliative Care;
- Ann Ryan, Unit Manager, Palliative Care;
- Linda Hauralli, RN Palliative Care;
- Janet O'Brien, PCA Palliative Care; and
- Dr Christine Sanderson, Palliative Care Doctor (Medical Director).

Alice Springs Baptist Church

The Alice Springs Baptist Church facilitated a meeting with the following individuals:

- Gavin Brown, Alice Springs Baptist Church;
- Malcolm Auld, Chair, Alice Springs Ministers Fellowship (via Zoom);
- Paul Traeger, Support Worker, Finke River Mission (Lutheran);
- Jane Bannister, Anglican Church Congregation; and
- Peter Bannister, Anglican Church Congregation.

Australian Christian Lobby

The Committee met with Nicholas Lay, NT Director of the Australian Christian Lobby.

Old Timers Aged Care

The Committee had a site visit at Old Timers Aged Care, a facility run by ARRCS. The Committee met with staff and residents, including:

- Michael Coughwan, Executive Manager, First Nations Programs ARRCS;
- Yanja Thompson, First Nations Project and RAP Officer;
- Richav Sedai, Clinical Research Nurse;
- Joanne Moody, Leisure/Lifestyle Coordinator;
- Catherine Hampton, Operations Manager, Multisite;
- Margaret Blum, resident;
- Josephine Kelihen, resident;
- Vern Ellis, resident;
- Martha Bevan, resident;
- Beverly Devine;
- Jeanne Lindsey, resident; and
- Betty Edwards, resident.

Maningrida – 25 August 2025

The Committee met with representatives of the following Maningrida Local Organisations at a private briefing in Darwin on 25 August 2025. The Committee met with:

- Charlie Gunabarra, Chairperson, Mala'la Health Service Aboriginal Corporation;
- Lesley Woolf, Executive Health Manager, Mala'la Health Service Aboriginal Corporation;
- Kira Bourke, CEO, Bawinanga Homelands Aboriginal Corporation (via Microsoft Teams);
- David Wuridjal Jones, Chairperson, Nja-marleya Cultural Leaders & Justice Group;
- Seide Ramadani, CEO, Nja-marleya Cultural Leaders & Justice Group (via Microsoft Teams);
- Shane Namanurki, Chairperson, Maningrida Progress Association;
- Adam Longbottom, CEO, Dukurrdji Development Corporation (via Microsoft Teams);

- Nic Sharrah, CEO, Homelands School Company (via Microsoft Teams);
- James Woods, Mayor, West Arnhem Regional Council; and
- Katharine Murray, CEO, West Arnhem Regional Council.

Numbulwar – 26 August 2025

The Committee travelled to Numbulwar on 26 August 2025. The Committee was supported by Roper Gulf Regional Council and assisted by an AIS interpreter, Rita Ngalmi, to facilitate discussions in Nunggubuyu.

Aged Care Centre

The Committee met with local aged care clients in the Numbulwar Aged Care Centre (Roper Gulf Regional Council). The Committee met with the following individuals:

- Pamela Warg;
- Bellama Anagua;
- Wulja Nunggarrgula;
- Margaret Miriniyowan;
- Nanette Murrugun;
- Mara Murrugun;
- Guyumayag Nyalmi;
- Kevin Murrugun; and
- Mawungumain Nundhirribala.

Community Drop-in Session

The Committee held an open forum for community consultation. The Committee met with:

- Kathy-Anne Numamurdirdi, Councillor (Numbulwar Nurburindi Ward), Roper Gulf Regional Council; and
- Reverend Bundur Rami, Church of the Holy Spirit.

Tennant Creek – 27 and 28 August 2025

The Committee travelled to Tennant Creek on 27 August 2025.

Barkly Regional Council and Tennant Creek Local Authority

On 27 August 2025, the Committee met with Patta Councillors and Tennant Creek Local Authority (TCLA), including:

- Sid Vashist, Mayor;
- Lennart (Len) Holbrok, TCLA;
- Pennie Cowin, Councillor; and
- Greg Marlow, Councillor.

Pulkapulkka Kari Flexible Aged Care

On 27 August 2025, the Committee visited the Pulkapulkka Kari Flexible Aged Care, a facility run by ARRCS. The Committee met the following staff:

- Loida Penez, Enrolled Nurse;
- Mijina Borotu, Registered Nurse;
- Sovaia Silibau, Leisure and Lifestyle;
- Peni Raiwalui, Leisure and Lifestyle;
- Tania Forsyth, Endorsed Enrolled Nurse;
- Lavenia Aleamotia, Registered Nurse; and
- Irene Snell, Service Manager.

Community Drop-in Session

On 27 August 2025, the Committee held an open forum for community consultation. The Committee met with the following individuals:

- Amy James, disability advocate;
- Alba Brockie, disability advocate; and
- Chris Kinross, Tennant Creek Public Library.

Tennant Creek Mob Aboriginal Corporation

On 28 August 2025, the Committee met with the Tennant Creek Mob Aboriginal Corporation, including:

- Jacqueline Bethel, CEO;
- Josephine Bethel, Youth Program Manager; and
- Rekeisha Taylor, Night Patrol Manager.

Individual witness

On 28 August 2025, the Committee met with Romy Carey, CEO, Northern Territory Cattlemen's Association.

Julalikari Council Aboriginal Corporation

The Committee met with representatives of Julalikari Council Aboriginal Corporation, including Lachlan Wilkins, CEO and Mikeely Fraser.

Tennant Creek Hospital

The Committee visited Tennant Creek Hospital and met with Ruth Smith, Acting Clinical Nurse Educator, and Jack Gannon, a patient.

Darwin – 5 September 2025

The Committee held a public hearing in Darwin on Friday, 5 September 2025.

NT Health

The Committee heard from the following witnesses:

- Dr Paul Burgess, Acting Chief Health Officer;
- Dr Jeremy Chin, Chief Medical Officer; and
- Dr Kane Vellar, Consultant Psychiatrist, Palliative Care Consultant, and former member of the VAD Independent Expert Panel.

Australian Medical Association NT

The Committee heard from Dr John Zorbas, President of the Australian Medical Association NT.

Appendix 3: Drafting instructions report prepared by the Australian Centre for Health Law Research, Queensland University of Technology

Drafting Instructions for Model Voluntary Assisted Dying Legislation in the Northern Territory

Australian Centre for Health Law Research
Queensland University of Technology

Prof Ben White | Dr Madeleine Archer | Katherine Waller | Dr Katrine Del Villar | Denisha Tyler

September 2025

QUT Australian Centre for Health Law Research

Further enquiries

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September 2025

TESQA Provider ID PRV12079 Australian University – CRICOS No. 00213J

Contents

Introduction

Background

Voluntary assisted dying (VAD) is now legal in all Australian states and will soon be in the Australian Capital Territory. VAD is not currently legal in the Northern Territory (NT), and it is unlawful to end another person's life at their request or to assist another person to end their life. VAD was briefly legal in the NT under the *Rights of the Terminally Ill Act 1995* (*ROTI Act*). With the passing of the *ROTI Act*, the NT became the first Australian (and indeed international) jurisdiction to legalise VAD. However, the *ROTI Act* was overturned by the Federal Parliament in 1997, with all Territories prohibited from making VAD legislation.[1] The Commonwealth lifted this ban in 2022, with the effect that the NT is again permitted to legislate on VAD.[2]

During the period from 22 August 2023 to 23 May 2024, the Voluntary Assisted Dying Independent Expert Advisory Panel (the Panel) engaged with a broad range of Territorians to produce the Report into Voluntary Assisted Dying in the Northern Territory: Final Report 2024 (2024 Report). Recommendation 1 was that the NT should implement VAD legislation which broadly reflects the Australian model of VAD. The 2024 Report made a further 21 recommendations spanning a range of issues including a person's eligibility to access VAD, the request and assessment process, required oversight of VAD, and implementation of potential VAD legislation in the NT.

On 14 May 2025, the Attorney-General requested the Legal and Constitutional Affairs Committee (the Committee) of the Northern Territory Legislative Assembly to inquire into the 2024 Report. Part of the terms of reference for the Committee is to provide drafting instructions for model legislation to give effect to VAD in the NT, if the Committee recommends to the Assembly adopting VAD legislation.

The Committee published a Consultation Paper in July 2025 (the Consultation Paper) to seek further input on the potential model and implementation of VAD legislation in the NT as proposed by the 2024 Report. The Committee received written submissions from individuals and organisations on the matters outlined in the Consultation Paper. These submissions, as well as extensive community consultations, including in several remote locations, inform the Committee's deliberations and its Final Report which is due to the Attorney General on 30 September 2025 (2025 Report).

1 *Euthanasia Laws Act 1997* (Cth), s 3, schs 1-3. The *Euthanasia Laws Act 1997* (Cth) amended relevant federal legislation to remove the ability of the NT, the Australian Capital Territory and Norfolk Island to enact VAD legislation in the future.

2 In December 2022, the Commonwealth Parliament passed the *Restoring Territory Rights Act 2022* (Cth).

On 23 July 2025, the Committee appointed Professor Ben White and team (Australian Centre for Health Law Research, Queensland University of Technology (QUT)) as specialist legal advisors for the Committee's Inquiry to develop drafting instructions for model legislation to give effect to VAD in the NT. This document contains QUT's drafting instructions.

Scope of the drafting instructions

These drafting instructions are based on:

(a) the 2025 Report of the Committee;

(b) the Committee's Consultation Paper;

(c) the 2024 Report of the Panel;

(d) the *ROTI Act*; and

(e) other Australian VAD laws.

These drafting instructions give effect to the Committee's policy positions as set out in the 2025 Report. Where the Committee's view either aligns with or departs from the recommendations included in the 2024 Report, this is identified in the drafting instructions.

As per the scope of the QUT team's appointment, the drafting instructions do not provide–

(a) information related to the commencement of the NT's VAD legislation;

(b) information related to the consistency (or otherwise) of the legislative model with existing NT legislation;

(c) for consequential amendments;

(d) for delegated legislation (though reference to the making of Regulations and other regulatory instruments is included as appropriate in the drafting instructions; see also further below in this chapter); and

(e) other administrative detail.

Cultural safety

The 2024 Report recognises that approximately one third of NT residents identify as Aboriginal and/or Torres Strait Islander. The Committee's community consultations and the 2024 Report identified the need to ensure that any VAD legislation encapsulates cultural safety for Aboriginal and Torres Strait Islander peoples.

The QUT team was engaged as specialist legal advisors by the Committee and acknowledges it does not have specific expertise in cultural safety. These drafting instructions have endeavoured to address the cultural safety considerations raised within the Committee's community consultations and its report. However, ongoing consideration will be needed to ensure that the NT VAD legislation, other forms of accompanying regulation, and implementation of the VAD system are culturally appropriate for Aboriginal and Torres Strait Islander peoples.

Engagement with the 2024 Report's recommendations

These drafting instructions are intended to give effect to the views of the Committee included in the 2025 Report. In most cases, the Committee adopts the recommendations in the 2024 Report, but in other cases it departs from the 2024 Report and makes different recommendations.

Most of the 2024 Report's recommendations have been addressed (adopted or departed from) in the drafting instructions directly. However, we note that some of the 2024 Report's recommendations do not require specific legislative implementation and instead are more general in nature.[3] For instance, Recommendation 7 includes that further resources about the nature and scope of palliative care should be included in community education. It was not generally within scope for the drafting instructions to address those wider system-, healthcare-, or community-level recommendations.

We also make some specific comments here about two of these more general recommendations:

(a) Recommendation 1 is that the NT should implement VAD legislation that is broadly consistent with the legislation in the other Australian jurisdictions. This recommendation is reflected across the drafting instructions as they regularly draw on the broad Australian model of VAD.[4]

(b) Recommendation 2 is that a single, centralised service should be developed to deliver VAD in the NT (centralised service). The Committee departs from this recommendation in the 2025 Report. While leaving open the possibility of a centralised service being developed to deliver VAD services in the NT in future, the Committee's view is that VAD will be provided in the NT via a decentralised delivery model. This reflects the broader Australian approach to providing VAD via the public and private sectors (which includes general practitioners). Accordingly, the drafting instructions were developed to facilitate a decentralised delivery model while leaving open the possibility of a future centralised model of VAD service delivery.

Issues which may be addressed in other regulatory tools (outside of legislation)

If VAD is implemented in the NT, it will be governed by a range of regulatory tools, one of which is legislation. Other regulatory tools may include Regulations, CEO requirements, clinical guidelines, medication protocols and training. For example, the 2024 Report states that it will be important to establish clinical guidelines for VAD in the NT to ensure that health practitioners have a comprehensive understanding of VAD and their legal responsibilities.[5]

These drafting instructions focus on giving effect to those issues in the 2025 Report (and 2024 Report insofar as it was adopted by the Committee) which are appropriately included in the NT's VAD legislation. However, the instructions also recognise various places where other regulatory tools may be more appropriate. For example, these drafting instructions recognise the role of CEO requirements to provide additional supervision of who may be a VAD practitioner.

3 Northern Territory Government Expert Advisory Panel, *Report into Voluntary Assisted Dying in the Northern Territory: Final Report 2024* (July 2024), Recommendations 1, 2, 6, parts of Recommendation 7, and Recommendation 22 ('2024 Report').

4 See generally Katherine Waller et al, 'Voluntary Assisted Dying in Australia: A Comparative and Critical Analysis of State Laws' (2023) 46(4) *University of New South Wales Law Journal* 1421.

5 2024 Report, p 43.

Structure of the drafting instructions

The drafting instructions consist of eight chapters. Chapters 1 to 7 reflect key components of VAD legislation which were covered in the 2024 and 2025 Reports. Chapter 8 does not contain drafting instructions but considers the role of other forms of regulation in governing VAD and key issues to consider if VAD legislation is implemented in the NT.

Chapters 1 to 7 generally adopt the following structure for each specific issue:

(a) synthesis of the Committee's policy position, including how this relates to the recommendations of the 2024 Report;

(b) brief discussion of policy considerations which inform the drafting instructions (if relevant); and

(c) drafting instructions which give effect to the policy position and any relevant policy considerations.

Glossary

This section provides some brief definitions of terms used throughout the drafting instructions. This glossary should not be read as the 'definitions' or 'interpretation' section of the NT's VAD legislation; instead these definitions are provided to assist readers of the drafting instructions. Where specific terms are intended to carry a specific meaning in the drafting instructions, a definition is included in the relevant chapter.

Notes on the glossary

The drafting instructions generally adopt the terms and definitions used in the 2024 Report.

The drafting instructions also make reference to the NT Health organisational structure consistent with the NT Governance Framework referred to in the 2024 Report.[6]

Because it is outside the scope of the drafting instructions to engage with other NT legislation, they do not consider if these terms have been defined or used elsewhere.

These drafting instructions generally use the term 'person' to refer to the person accessing VAD and undergoing the request and assessment process. The term 'patient' is sometimes also used where necessary to emphasise the person's clinical relationship with a health practitioner.

6 2024 Report, p 15.

Term	Definition
2024 Report	Report into Voluntary Assisted Dying in the Northern Territory: Final Report 2024.
2025 Report	Report of Legal and Constitutional Affairs Committee: Final Report 2025.
Administration Decision	A clear and unambiguous decision made by the person accessing VAD, in consultation with and on the advice of their Coordinating Practitioner, as to whether the person will self-administer the VAD substance, or have the substance administered to them by an Administering Practitioner. See Chapter 4.
Administering Practitioner	An Authorised VAD Practitioner who administers the VAD substance to an eligible person who has made a Practitioner Administration Decision in the presence of a witness.
Authorised VAD Practitioner	A practitioner who meets the eligibility requirements to be a participating health practitioner in the VAD process including being approved by the CEO. See Chapter 5.
Centralised Service	As defined in the 2024 Report: 'A stand-alone single service for the delivery of VAD.'
CEO	The Chief Executive Officer of the NT Department of Health.
CHO	The NT Chief Health Officer.
Conscientious objection	The position of a person who declines to participate in a lawful process, such as VAD, due to their personal beliefs, values, or moral concerns. See Chapter 6.
Coordinating Practitioner	An Authorised VAD Practitioner (see Chapter 5) who accepts a person's First Request.
Consulting Practitioner	An Authorised VAD Practitioner (see Chapter 5) who accepts a referral to conduct a Second Assessment for the person.
Cultural safety	As defined in the National Agreement on Closing the Gap: 'Cultural safety is met through actions from the majority position which recognise, respect, and nurture the unique cultural identity of Aboriginal and Torres Strait Islander people. Only the Aboriginal and Torres Strait Islander person who is recipient of a service or action can determine whether [the service or action] is culturally safe.'[7]
Decentralised model of VAD service delivery	In contrast to a centralised service model (a stand-alone service), a decentralised model of VAD service delivery involves VAD provision through the public and private sectors (including general practitioners).
Decision-making capacity	A person's capability to understand and make decisions about VAD. See Chapter 2.
Drafting instructions	QUT's drafting instructions that give effect to the policy positions of the Committee as included in the 2025 Report.

7 Closing the Gap, National Agreement on Closing the Gap (webpage, July 2020) <https://www.closingthegap.gov.au/national-agreement/national-agreement-closing-the-gap>.

Family Member	The person's spouse, parent, grandparent, sibling, child or grandchild or a person who, under Aboriginal tradition or Torres Strait Island custom, is regarded as family.
First Assessment	An Assessment conducted by the Coordinating Practitioner to assess whether the person is eligible for access to VAD by determining whether they meet all of the eligibility criteria (see Chapter 3 for criteria for a valid First Assessment).
First Request	A clear and unambiguous explicit request, by the person, for assistance to die. It is made to a medical practitioner by the person themselves (see Chapter 3 for criteria for a valid First Request).
Health or care entity	A facility which provides health and/or care services to persons who, because of infirmity, illness, disease, incapacity or disability, have a need for nursing or personal care. It includes hospitals, hospices, and residential aged care facilities. See Chapter 6.
NTCAT	The Northern Territory Civil and Administrative Tribunal.
Practitioner Administration	The method of administration of a VAD substance following a Practitioner Administration Decision in which the person chooses for an Authorised VAD Practitioner to administer the VAD substance to them.
Review Board	The statutory review body created by the NT VAD legislation whose functions include the oversight and monitoring of VAD in the NT.
Self-Administration	The method of administration of a VAD substance following a Self-Administration Decision in which the person chooses to self-administer a VAD substance at a time of their choosing.
Second Assessment	An assessment conducted by the Consulting Practitioner to assess whether the person is eligible for access to VAD by determining whether they meet each of the eligibility criteria (see Chapter 3 for criteria for a valid Second Assessment).
VAD care navigator service (or official VAD care navigator service)	An official VAD service which provides support, assistance and information to people relating to VAD.
VAD substance	A substance approved for the purposes of providing VAD.
Voluntary assisted dying (VAD)	Where an eligible person chooses to access and receive assistance to die in accordance with the VAD legislation.

QUT team

These drafting instructions were prepared by the QUT team at the Australian Centre for Health Law Research:

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(c) Katherine Waller, Project Manager – Voluntary Assisted Dying Training;

(d) Dr Katrine Del Villar, Senior Lecturer; and

(e) Denisha Tyler, Research Assistant.

Disclosures

The QUT team discloses that Professor Ben White made submissions (with Professor Lindy Willmott) to the Legal and Constitutional Affairs Committee in relation to its inquiry into Voluntary Assisted Dying on 15 July 2025 and to the Voluntary Assisted Dying Independent Expert Advisory Panel on 13 February 2024.

These drafting instructions give effect to the policy positions of the Committee. They do not necessarily reflect the views of the QUT team, the Australian Centre for Health Law Research, or QUT.

Chapter 1
Preliminary Provisions

Policy position

1.1 The drafting instructions in this chapter address preliminary provisions in the NT VAD legislation. They are consistent with the VAD legislation in other Australian jurisdictions, and such provisions are routinely included in other NT legislation.

Drafting instructions

Purpose of legislation

1.2 The purposes of the NT VAD legislation are to:

(a) give persons who are suffering and dying and who meet eligibility criteria, a legally authorised option to hasten their death by medical assistance;[8]

(b) establish a lawful process for eligible persons to exercise that option;

(c) provide legal protection for health practitioners who assist persons to die in accordance with the legislation;

(d) establish safeguards to:

(i) ensure VAD is accessed only by persons who have been assessed as eligible; and

(ii) protect vulnerable persons from coercion and exploitation;

(e) establish a Review Board and other mechanisms to ensure compliance with this legislation; and

(f) recognise the unique demography and geography of the NT in which VAD will be delivered.

8 2024 Report, p 19.

Principles of VAD

1.3 The principles that underpin the proposed legislation are:

(a) every human life is of fundamental importance;

(b) a person's autonomy, including autonomy in relation to informed end-of-life choices, should be respected;

(c) a person's decision to include chosen others in decision-making about end-of-life choices should be respected;

(d) a person should be supported in making informed decisions about end-of-life choices;

(e) a person approaching the end of life should be provided with high quality care and treatment, including palliative care and treatment, to minimise the person's suffering and maximise the person's quality of life;

(f) a therapeutic relationship between a person and the person's registered health practitioner should, wherever possible, be supported and maintained;

(g) a person should be protected from coercion and exploitation;

(h) access to VAD and other end-of-life choices should be available regardless of where a person lives in the Northern Territory;

(i) a person should be supported in conversations with the person's registered health practitioner, members of the person's family and carers and community about treatment and care preferences;

(j) all persons, including registered health practitioners, have the right to be shown respect for their culture, religion, beliefs, values and personal characteristics; and

(k) a person has the right to cultural safety in relation to VAD, other end-of-life care, and health care in general.

Voluntary assisted dying is not suicide

1.4 For the purposes of the law of the Territory, a person who dies following the administration of a VAD substance in accordance with the legislation does not:

(a) die by suicide; and

(b) is taken to have died by the disease, illness or medical condition that made them eligible to access VAD.

Chapter 2
Eligibility Requirements

2.1 The Committee adopts the 2024 Report that eligibility criteria for VAD in the NT should broadly be consistent with those in other Australian jurisdictions, unless the conditions in the Territory require a different response.[9] The Committee recommends departing from the 'Australian model'[10] of eligibility criteria only in relation to the timeframe to death.

Residency

Policy position

2.2 The Committee adopts Recommendation 8 of the 2024 Report.

Australian residence

2.3 To access VAD in the NT, a person should ordinarily have resided in Australia for two years.

Territory residence

2.4 In addition, a person should ordinarily have resided in the Territory for 12 months.

Exceptions

2.5 A person who is not a resident in the NT, but lives in a cross-border community should be eligible to access VAD in the NT.

2.6 Persons with family, cultural, or support links to the NT should be able to return to the NT to access VAD in the context of their personal support networks.

9 2024 Report, p 56.

10 Katherine Waller et al, 'Voluntary Assisted Dying in Australia: A Comparative and Critical Analysis of State Laws' (2023) 46(4) *University of New South Wales Law Journal* 1421.

Policy considerations

Australian residence

2.7 The 2024 Report noted that the requirement of Australian citizenship or permanent residency has resulted in findings of ineligibility for some long-term Australian residents.[11]

2.8 The 2024 Report sought to address this issue by not restricting eligibility to Australian citizens or permanent residents but instead requiring only that a person has resided in Australia for two years before accessing VAD.

2.9 This streamlined Australian residence criterion will be effective to achieve the policy purpose of preventing 'VAD tourism': where residents of countries where VAD is not legal travel to countries where it is legal to access the service. It will also avoid some of the hardships which have been caused by the permanent residence criterion in state VAD legislation for long-term Australian residents who have not formally received permanent resident status.

2.10 The two-year Australian residency requirement is broadly consistent with the legislation in Queensland, Tasmania and New South Wales, which allows persons who have been resident in Australia for at least three years to request access to VAD.[12]

2.11 However, only having the two-year Australian residency criterion will result in some Australian citizens who are temporarily living overseas being excluded from accessing VAD in the NT.[13]

2.12 All Australian jurisdictions also allow a person who is an Australian citizen to access VAD. This alternative allows an Australian who is not currently living in Australia to return home to family after being diagnosed with a terminal illness and be eligible to access VAD, subject to state or territory residency requirements. The below drafting instructions recommend inclusion of this alternative criterion as well as the two-year Australian residency requirement.

11 2024 Report, p 56; see also Katrine Del Villar, Lindy Willmott and Ben White, 'The Exclusion of Long-Term Australian Residents from Access to Voluntary Assisted Dying: A Critique of the "Permanent Resident" Eligibility Criterion' (2023) 49(2) *Monash University Law Review* 1.

12 *Voluntary Assisted Dying Act 2022* (NSW) s 16(1)(b)(iii); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 11(1)(a)(iii); *Voluntary Assisted Dying Act 2021* (Qld) s 10(1)(e)(iii).

13 See *EF, GH, IJ and KL* [2024] WASAT 18.

Territory residence

2.13 The 2024 Report noted that the NT is the only jurisdiction in Australia which does not currently have a VAD law. It therefore observed that there does not appear to be a compelling need for a domestic residency requirement.[14] There is some tension within the 2024 Report, however, because the Panel recommended that a person should reside in the Territory for 12 months before being eligible to access VAD.[15]

2.14 Given the Committee's recommendation that no timeframe to death be included in the NT's VAD legislation, there is a possibility that persons from Australian states where a six-month timeframe to death applies may seek to access VAD in the NT. A requirement to have been resident in the Territory for 12 months before making a request for VAD will prevent this occurring.

2.15 A 12-month domestic residency requirement will exclude new residents of the NT who receive a terminal diagnosis after moving to the Territory from accessing VAD. It will also introduce complications for Territorians who live a nomadic lifestyle for work or personal reasons. These issues can be ameliorated by the inclusion of exceptions.

Exceptions

2.16 The 2024 Report recommended two exceptions.[16] One is to allow a person who is not resident in the NT, but lives in a community close to the NT border, to access VAD in the Territory.

2.17 This exception will provide flexibility for residents of border communities, who may be closer to a town or medical services in the NT than in their home state.

2.18 The Report also recommended an exception for persons with family, cultural, or support links to the NT. This exception may be relevant to both the Australian residence and Territory residence requirement.

Drafting instructions

2.19 The legislation should provide that to be eligible to access VAD in the NT, a person should either be an Australian citizen or have ordinarily resided in Australia for two years.

2.20 A person should also have been ordinarily resident in the Territory for 12 months. An exemption should apply to a person who is not resident in the NT, but lives in a community close to the NT border.

2.21 An exception to both the Australian citizen or resident requirement and the Territory residence requirement should apply to a person who has family, cultural, or support links to the NT. This will enable such a person to return to the Territory to access VAD in the context of their personal support networks.

14 2024 Report, p 56; this point was also made by Katrine Del Villar, Ruthie Jeanneret and Ben White, 'When Safeguards Become Stumbling Blocks: A Call to Remove the State Residence Requirement for Voluntary Assisted Dying in Australia' (2025) 48(2) *University of New South Wales Law Journal* 611.

15 2024 Report, Recommendation 8.

16 2024 Report, Recommendation 8.

Age

Policy position

2.22 The Committee adopts Recommendation 9 of the 2024 Report.

2.23 A person must be aged 18 or over to be eligible to access VAD in the NT.

Drafting instructions

2.24 The legislation should provide that a person must be aged 18 or over to be eligible to access VAD in the NT.

Medical Condition

Policy position

2.25 The Committee departs from Recommendation 10 of the 2024 Report and proposes that a person should have a condition that is 'advanced, progressive and expected to cause death' (rather than the recommended 'serious and incurable condition'). The Committee also recommends that a timeframe to expected death should not be included in the NT VAD legislation. The Committee adopts Recommendation 10 of the 2024 Report that a person's condition must cause intolerable suffering that cannot be relieved in a manner that they feel is acceptable.

Medical condition

2.26 The 2024 Report noted that legislation across the Australian jurisdictions is broadly consistent. In all jurisdictions, the established parameters require a person to have an advanced and progressive condition that is causing intolerable suffering and will lead to death within a specified timeframe to be eligible to access VAD.[17]

2.27 The Panel received submissions to broaden the eligibility criteria to persons with serious but non-terminal conditions, people with dementia, and people without a medical condition who feel they have led a full but 'completed' life. The 2024 Report concluded these extensions would be a significant departure from the Australian model.[18]

17 2024 Report, p 57.

18 2024 Report, p 58.

Timeframe to death

2.28 In all Australian states except Queensland, VAD laws contain a differential timeframe to death depending on the person's diagnosis: death must be expected to occur within six months except for neurodegenerative illnesses (12 months).[19] The Australian Capital Territory legislation does not include a timeframe to death.[20]

2.29 While the 2024 Report recommended the Queensland approach that the legislation contain a single 12-month timeframe for all conditions, the Committee recommends that the legislation does not include a timeframe to death.[21]

Suffering

2.30 The Panel noted that the person's medical condition should be causing intolerable and enduring suffering. Whether suffering can be relieved by available treatment or care is subjectively determined by the person.

Policy considerations

Medical condition

2.31 In all Australian jurisdictions, access to VAD is limited to persons who have a terminal illness. This reflects the conception of VAD as another end-of-life option for people who are already dying.

2.32 The Panel proposed that the NT follow the approach in other Australian jurisdictions. VAD legislation nationally requires a person to have an 'advanced and progressive' condition that will cause death within a specified timeframe to be eligible to access VAD. The drafting instructions have hence used this terminology. It is noted that the recommendation refers to a 'serious and incurable' condition but this reflects the language used in the Canadian VAD legislation rather than the Australian jurisdictions.

2.33 Three Australian states also include a requirement that a person's condition be 'incurable' to access VAD. In Tasmania, the legislation explicitly defines this subjectively – referring to a condition that is not able to be cured or reversed by treatments that are acceptable to the person.[22] This was also the position taken in the *ROTI Act*.[23] In Victoria and South Australia, the meaning of 'incurable' is not defined. Statements by the Victorian Health Minister at the time suggest that it should be understood objectively to mean that there are no curative medical treatments available.[24]

2.34 If a person is required to be diagnosed with a condition that is advanced and progressing towards an expected death to access VAD, it is not necessary to also state that the person's condition be 'incurable'. This would introduce additional complications about whether incurability should be medically determined or determined by reference to treatments the person finds acceptable.

2.35 To be consistent with other Australian jurisdictions, the NT should require a person to be suffering intolerably from a condition that is advanced, progressive and expected to cause death.

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19 Katherine Waller et al 'Voluntary Assisted Dying in Australia: A Comparative and Critical Analysis of State Laws' (2023) 46(4) *University of New South Wales Law Journal* 1421.

20 *Voluntary Assisted Dying Act 2024* (ACT), s 11(1)(b).

21 2024 Report, Recommendation 10.

22 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 6(2).

23 *ROTI Act*, s 7(1)(b)(ii).

24 Ben White et al, 'Comparative and Critical Analysis of Key Eligibility Criteria for Voluntary Assisted Dying under Five Legal Frameworks' (2021) 44(4) *University of New South Wales Law Journal* 1663, 1670-71.

Timeframe to death

2.36 In most Australian jurisdictions, the VAD legislation initially proposed that a person should be able to request VAD if their death is expected to occur within 12 months. The 2024 Report observed that the shorter six-month timeframe to death for physical conditions in most states was a result of political compromise during the parliamentary process.[25]

2.37 The Panel observed there are particular challenges to accessing timely health services and support in the NT, especially for those living in remote areas.[26]

2.38 The Panel's recommendation for a 12-month timeframe to death irrespective of a person's illness is consistent with the Queensland legislation. This additional time will also minimise access barriers for persons living in remote areas, and allow them time to get the necessary approvals.[27]

2.39 However, the Committee considered evidence that it can be difficult for medical practitioners to reliably estimate a person's prognosis outside of a narrow window of days or weeks. It also concluded that the requirement that a person's condition be 'advanced, progressive and expected to cause death' constitutes sufficient safeguards. For these reasons, it concluded that the additional requirement of a specific timeframe to death is not required.

Suffering

2.40 In all Australian jurisdictions, the existence of, and level of, suffering is subjectively determined by the person. The NT proposal is consistent with this. It is proposed, as in some Australian models, that it is expressly stated that suffering can include both physical and mental suffering.

2.41 VAD legislation in other Australian jurisdictions stipulates that the person's medical condition must be the cause of the person's suffering. In Queensland, Tasmania and the Australian Capital Territory, the legislation expressly includes suffering caused by treatment for the person's medical condition.[28]

2.42 In Tasmania and the Australian Capital Territory, suffering can also be caused by anticipation of future suffering likely to be caused by the condition or its treatment.[29]

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25 2024 Report, p 58; see also the discussion in Ben White et al, 'Does the Voluntary Assisted Dying Act 2017 (Vic) Reflect Its Stated Policy Goals?' (2020) 43(2) *University of New South Wales Law Journal* 417.

26 2024 Report, p 58.

27 2024 Report, p 58.

28 See generally Katherine Waller et al 'Voluntary Assisted Dying in Australia: A Comparative and Critical Analysis of State Laws' (2023) 46(4) *University of New South Wales Law Journal* 1421, 1430.

29 *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas) s 14(b)(ii), (iv) and (vi); *Voluntary Assisted Dying Act 2024* (ACT) s 11(4)(a)(ii).

Drafting instructions

2.43 To be consistent with established Australian eligibility frameworks, the legislation should provide that:

(a) to access VAD in the NT, a person must have an advanced and progressive condition which is expected to cause death;

(b) the person's medical condition, or treatment for that condition, must be causing intolerable and enduring suffering (physical, mental or both) that cannot be relieved in a manner the person feels is acceptable; and

(c) suffering can also be caused by anticipation or expectation, based on medical advice, of future treatment or the progression of the medical condition.

Capacity

Policy position

2.44 The Committee adopts Recommendation 11 of the 2024 Report.

2.45 The 2024 Report recommended that a person must have capacity at all stages throughout the VAD process, including the Formal Request, and the Administration Decision.[30]

2.46 A person should not be presumed to lack capacity to make end-of-life choices because they have an illness, an intellectual disability, or lack capacity for certain other choices, such as financial decisions.[31]

30 2024 Report, p 59.

31 2024 Report, p 59.

Policy considerations

2.47 The requirement that a person must have capacity at all stages of the VAD process is an important safeguard for the person, and also for participating health practitioners.

2.48 The VAD legislation in other Australian jurisdictions explains the notion of decision-making capacity to clarify that it should not be narrowly construed.[32] All Australian jurisdictions expressly state the common law presumption that a person has capacity unless there is evidence to the contrary.

2.49 Most VAD laws also expressly recognise that a person's capacity may fluctuate from time to time, that a person may have capacity for some decisions but not others, and that an unwise decision is not automatic evidence of incapacity.

2.50 A majority of Australian jurisdictions (Australian Capital Territory, Queensland, Victoria, South Australia) also specify that a person can be considered to have decision-making capacity if they are able to make the decision to access VAD with adequate and appropriate supports.

2.51 While recognising community desire in the NT for people to be able to request VAD in an advance directive, the Panel preferred to align the NT framework with the Australian model and restrict access to VAD to persons who retain capacity up to the time of administration.[33]

Drafting instructions

2.52 The legislation should provide that to be eligible to access VAD in the NT, a person must have decision-making capacity in relation to VAD.

2.53 A person must have decision-making capacity in relation to VAD at all stages of the VAD process, including the First Request, Formal Request, and the Administration Decision.

2.54 A person should be presumed to have capacity unless there is evidence to the contrary.

2.55 A person can be considered to have decision-making capacity if they are able to make the decision to access VAD with adequate and appropriate supports.

2.56 A person's capacity may fluctuate from time to time.

2.57 A person should not be presumed to lack capacity in relation to VAD because:

(a) they have an illness or disability, including an intellectual disability or mental illness;

(b) they lack capacity in relation to other decisions;

(c) they make a decision that others disagree with; or

(d) of a personal characteristic, such as age, appearance, or language skills.

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32 See Katherine Waller et al 'Voluntary Assisted Dying in Australia: A Comparative and Critical Analysis of State Laws' (2023) 46(4) *University of New South Wales Law Journal* 1421, 1432–1433.

33 2024 Report, p 59.

Voluntariness

Policy position

2.58 The 2024 Report did not make a specific recommendation that VAD must be the voluntary choice of a person. However, consistent with Recommendation 1 of the 2024 Report, the Committee recommends including this criterion.

2.59 Consistent with the Australian model of VAD, it is essential that a person's request for VAD is a voluntary choice and not the result of undue influence or coercion.

Policy considerations

2.60 In all other Australian jurisdictions except Victoria, one of the eligibility criteria is that a person is acting voluntarily, and without coercion in making a request for VAD.[34] One of the eligibility criteria under the *ROTI Act* was that the person's decision to request VAD was made freely, voluntarily and after due consideration.[35] This criterion reinforces the foundational principle that access to VAD must be entirely voluntary.

2.61 The 2024 Report recognised that culturally safe kinship decision-making should be accommodated and that concerns about coercion should be balanced against a person's request for family involvement.[36] The Committee heard clear evidence from Indigenous communities that they desire the ability to make decisions in accordance with their traditions and customs, which includes involvement of elders, family members or traditional healers.

2.62 The Panel noted that a person may freely and voluntarily request that decisions about medical treatment and access to VAD be made for the person by family members or culturally significant decision-makers on the person's behalf.[37]

2.63 The inclusion of communal methods of decision-making raises difficult issues for evaluating whether a person's decision is voluntary. Guidelines relating to ensuring VAD is a person's voluntary choice in the context of family or kinship decision-making should be included in the Territory's formal clinical guidance.

34 Katherine Waller et al 'Voluntary Assisted Dying in Australia: A Comparative and Critical Analysis of State Laws' (2023) 46(4) *University of New South Wales Law Journal* 1421, 1433.

35 *ROTI Act* s 7(1)(h).

36 2024 Report, p 126.

37 2024 Report, p 126.

Drafting instructions

The legislation should provide that:

2.64 To be eligible for VAD in the NT, a person must be acting voluntarily and without coercion.

2.65 A person may voluntarily request family members or other culturally important decision makers to be involved in making a VAD decision in accordance with culturally accepted practices of decision-making.

2.66 The drafters will need to consider how this interacts with the requirements for VAD requests.

Excluded Conditions

Policy position

2.67 The Committee adopts Recommendation 11 of the 2024 Report. The Committee goes beyond this and also recommends VAD should not be available for persons solely on the basis of disability.

Mental Illness

2.68 The 2024 Report recommended that persons should not be eligible for VAD solely on the basis of a diagnosis of mental illness, as mental illness is not a terminal condition.[38]

2.69 A person who has a mental illness and is otherwise eligible for VAD on the basis of a terminal illness (including retaining decision-making capacity) should not be excluded from accessing VAD.[39]

Dementia

2.70 The recommendation that a person should have decision-making capacity at all stages during the VAD process effectively excludes the option of accessing VAD through a request made in an advance directive.

2.71 The Panel acknowledged that it is very unlikely a person with dementia would retain capacity once their condition is advanced.[40]

Disability

2.72 The 2024 Report did not make a recommendation to exclude persons from accessing VAD solely on the basis of a disability.

38 2024 Report, p 59.

39 2024 Report, p 59.

40 2024 Report, Appendix 10, p 128.

Policy considerations

Mental Illness

2.73 The recommendation to exclude persons from accessing VAD solely on the basis of a diagnosis of mental illness is consistent with the legislation other Australian jurisdictions.

Dementia

2.74 The Panel acknowledged a strong desire among Territorians to be able to access VAD if diagnosed with dementia.[41] It also acknowledged the complex legislative issues this raises. Allowing access to VAD by persons with dementia involves either relaxing the eligibility requirements to allow people in the early stages of dementia to access VAD while still competent, or allowing access through an advance directive or request.[42]

2.75 The Panel noted concerns about patient safety, vulnerability, elder abuse and inheritance impatience among relatives. They also noted a high proportion of health practitioners reported difficulty accurately evaluating capacity in persons with dementia.[43]

2.76 The Panel was reluctant to depart from the established VAD framework in force in other Australian jurisdictions to extend access to VAD to persons with dementia.[44]

Disability

2.77 All Australian jurisdictions provide that a person is not eligible to access VAD solely on the basis of a disability.

2.78 This conclusion is already implicit in the requirement that a person be suffering from a medical condition which is advanced and progressive and which is expected to cause death. However, to be consistent with other Australian jurisdictions, it may be desirable to make this explicit, for the avoidance of doubt.

Drafting instructions

2.79 To be consistent with the Australian model, the legislation should provide that a person with a mental illness or a disability may be eligible for VAD, but they would not be eligible on the sole basis of a mental illness or disability.

41 2024 Report, p 59.

42 2024 Report, pp 128-130.

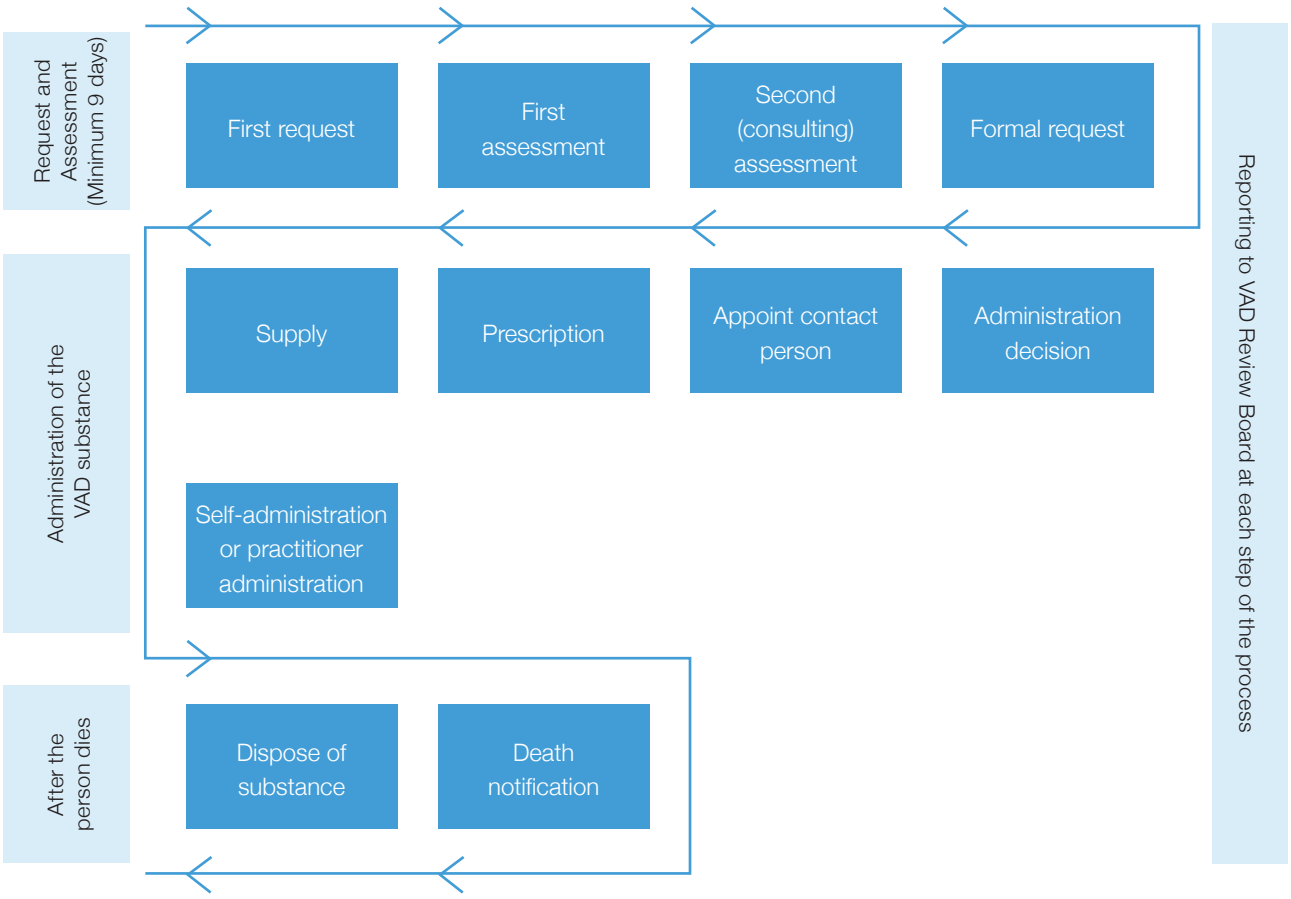
43 2024 Report, pp 128-130.

44 2024 Report, p 130.

Chapter 3
Request and Assessment Process

Overview of the process

Diagram of key steps in the request and assessment process



Mandatory reporting

3.1 Each step of the request and assessment process must be documented in the patient's medical record and reported to the Review Board in an approved form and within two business days of completing the step.

Initiating discussions about VAD

Policy Position

3.2 The Committee adopts Recommendation 12 of the 2024 Report.

3.3 Medical practitioners should be able to initiate conversations about VAD with a patient provided that the practitioner also informs the patient about all available treatment options and palliative care options.

Drafting instructions

3.4 The legislation should provide that medical practitioners are permitted to initiate conversations about VAD with a person in the context of a medical consultation, as long as they also inform the patient about:

(a) all treatment options available to the person; and

(b) the nature, scope and availability of palliative care services.

3.5 Other healthcare workers may initiate conversations about VAD with a person in the context of providing care, as long as they also inform the person that a medical practitioner would be the most appropriate person with whom to discuss the VAD process and other treatment and palliative care options.

3.6 There should be no restrictions on healthcare workers being able to provide information about VAD to a person who has requested it.

3.7 Once the topic of VAD has been discussed, there should be no restrictions on further discussions (including in future consultations).

3.8 The legislation should provide that in this section, 'healthcare worker' means:

(a) a registered health practitioner; or

(b) another person who provides a health service or personal care service.

First Request

Policy position

3.9 The 2024 Report provides limited information about the requirements of a First Request. It notes that the first step in the process will involve making a request to be assessed by a VAD practitioner and that upon making an initial request, patients should be referred immediately to a centralised VAD service.

3.10 The Committee adopts the guidance provided in the 2024 Report and recommends that the process for making a First Request should be consistent with the 'Australian model of VAD'. However, the Committee is of the view that a model for delivering VAD should not be built into the legislation.

Policy considerations

3.11 In other Australian jurisdictions, the formal process commences when a person makes a clear and unambiguous First Request for VAD. In all States, to be valid, a First Request must be made to a medical practitioner. In the Australian Capital Territory, a First Request can also be made to a nurse practitioner.

3.12 The legislation in each jurisdiction details the steps that practitioners must take upon receiving a First Request. This includes circumstances in which the practitioner may or must refuse to accept the First Request, the timeframes in which the request should be accepted or refused, and any information that must be provided to the person at the time of the request.

Drafting instructions

3.13 Consistent with the process in other Australian jurisdictions, the formal process to access VAD in the NT should be triggered by a First Request. A First Request must be an explicit request, by the person, for assistance to die. The legislation should provide that the request can only be made to a medical practitioner and must:

(a) be made by the person themselves (and not by another person on their behalf); and

(b) be clear and unambiguous (noting that the request may be made verbally or by other means of communication available to the person).

3.14 The legislation should allow medical practitioners the choice to accept or refuse the First Request. It should provide that the medical practitioner:

(a) may refuse the request if:

(i) they have a conscientious objection to VAD; or

(ii) they are otherwise unwilling or unable to perform the duties of a Coordinating Practitioner;

(b) must refuse the request if they are not eligible to act as Coordinating Practitioner.

3.15 Generally, the medical practitioner should be required to notify the person whether they accept or refuse the First Request within two business days of receiving the request. However, the medical practitioner should be required to notify the person of their decision immediately if they refuse the request because they conscientiously object to VAD.

3.16 Upon receiving a First Request, all medical practitioners should give the patient the *approved information*.

3.17 The legislation should provide that a medical practitioner who receives a First Request must record the details of the request in the person's medical record (including the date of the request, the practitioner's decision to accept or refuse the request, and confirmation that the person was given the *approved information*).

3.18 A medical practitioner who accepts a person's First Request becomes the person's Coordinating Practitioner.

Assessments

Policy position

3.19 The Committee adopts Recommendation 14 of the 2024 Report.

3.20 Consistent with the 'Australian model of VAD', the assessment of a person's eligibility for VAD should be undertaken by two independent medical practitioners. The Coordinating and Consulting Practitioner must each assess whether the person meets all the eligibility requirements for VAD.

3.21 The legislation should outline the procedural requirements of the assessments, and guidance on how the assessments should be conducted should be provided in clinical guidelines.

3.22 While the 2024 Report proposed a departure from the 'Australian model of VAD' in relation to referrals for determination, the Committee considered it appropriate for the legislation to mandate a referral for determination in circumstances where the assessing practitioner is unable to determine whether the patient meets specific eligibility requirements.

Drafting instructions

First Assessment

3.23 The legislation should provide that the Coordinating Practitioner must assess whether the person is eligible for access to VAD by determining whether they meet each of the eligibility criteria.

3.24 In conducting their assessment, the Coordinating Practitioner should be permitted to consider relevant information prepared by other registered health practitioners.

3.25 If the Coordinating Practitioner is satisfied that the person meets all the eligibility criteria, they must assess them as eligible for access to VAD.

3.26 If the Coordinating Practitioner has determined that the person does not meet one or more of the eligibility criteria, they must assess the person as ineligible for access to VAD.

3.27 The legislation should include a process for the Coordinating Practitioner to refer a person assessed as eligible during the First Assessment to a Consulting Practitioner, for a Second Assessment.

Second Assessment

3.28 A medical practitioner who receives a referral from a Coordinating Practitioner to conduct a Second Assessment must accept or refuse the referral. The circumstances in which the practitioner may or must refuse to accept the referral, and the relevant timeframes, should be identical to those of the First Request (see paragraphs 3.13 and 3.14 above).

3.29 A medical practitioner who accepts the referral becomes the person's Consulting Practitioner.

3.30 The legislation should provide that the Consulting Practitioner must independently assess whether the person is eligible for access to VAD by determining whether they meet each of the eligibility criteria.

3.31 In conducting their assessment, the Consulting Practitioner should be permitted to consider relevant information prepared by other registered health practitioners.

3.32 If the Consulting Practitioner is satisfied that the person meets all the eligibility criteria, they must assess them as eligible for access to VAD.

3.33 If the Consulting Practitioner has determined that the person does not meet one or more of the eligibility criteria, they must assess the person as ineligible for access to VAD.

Information to be provided to a person who meets the eligibility criteria

3.34 The legislation should provide that a person who has been assessed as eligible must be provided with specific information by the Coordinating Practitioner as part of the First Assessment and then again by the Consulting Practitioner as part of the Second Assessment.[45]

3.35 The legislation should also require the Coordinating Practitioner to start discussing a plan for administering the VAD substance during the First Assessment.

Referral for determination

3.36 The Coordinating and Consulting Practitioner must refer the person to a registered health practitioner with appropriate skills and training for a determination if they are unable to determine whether the person:

(a) has a disease, illness or medical condition that meets the requirements set out in the eligibility criteria (see Chapter 2); or

(b) has decision-making capacity in relation to VAD.

3.37 The Coordinating and Consulting Practitioner must refer the person to another person with appropriate skills and training for a determination if they are unable to determine whether the person is acting voluntarily and without coercion.

3.38 If the Coordinating or Consulting Practitioner makes a referral under paragraphs 3.36 or 3.37, they may (but are not required to) adopt the determination.

3.39 A registered health practitioner or other person to whom a referral is made under paragraphs 3.36 or 3.37 must not be a Family Member of the person requesting VAD or stand to benefit from the person's death (financially or in another material way).

45 2024 Report, p 68.

Formal Request

Policy position

3.40 The Committee adopts Recommendation 15 of the 2024 Report.

3.41 Following the assessment process, a person who has been assessed as eligible for VAD may make a Formal (written) Request for VAD. While the 'Australian model of VAD' requires the person to make three requests for VAD (the second of which must be in writing), the Panel has recommended that the NT process consist of two requests; a First Request, and a Formal Request. The Panel did not consider whether, following the Final Request, the Coordinating Practitioner should undertake a Final Review,[46] as is generally required in the 'Australian model of VAD'. The below drafting instructions do not provide for this step, which primarily serves an administrative purpose.

3.42 Consistent with the 'Australian model of VAD', the request must generally be signed by the person and witnessed by two witnesses.

3.43 While the Formal Request should generally be provided via a written instrument, the Committee considered it appropriate for the legislation to set out video recording as an alternative way of communicating and documenting the request.

3.44 The Panel considered that excluding family members or culturally significant decision-makers, as occurs in other Australian jurisdictions, from being a witness is too restrictive. It proposed that one of the witnesses may be a beneficiary under the person's will.

3.45 To ensure that the person's request is enduring, there should be a minimum designated timeframe between the (accepted) First Request and the Formal Request. Consistent with the 'Australian model of VAD', this timeframe may be shortened in cases where the person may die or lose decision-making capacity.

3.46 Where an interpreter is involved in the Formal Request, they should certify that they provided a true and correct translation of relevant materials. To comply with this certification, the interpreter must also be qualified or credentialled as a translator in the required language.

Drafting instructions

Form of Formal Request

3.47 The legislation should provide that a person who has been assessed as eligible for VAD by the Coordinating and Consulting Practitioner may make a Formal Request for VAD.

3.48 The Formal Request must be in an approved form and signed in the presence of two eligible witnesses.

3.49 The person must certify that they are making the request voluntarily and understand the purpose of the Formal Request.

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46 See Katherine Waller et al 'Voluntary Assisted Dying in Australia: A Comparative and Critical Analysis of State Laws' (2023) 46(4) *University of New South Wales Law Journal* 1421, 1440.

3.50 The person is required to give the completed Formal Request to the Coordinating Practitioner.

Patient signature

3.51 If the patient is unable to sign the Formal Request, another adult can sign the Request in the presence of, and at the direction of the person. This other person cannot be the Coordinating or Consulting Practitioner, or one of the two witnesses.

Eligible witnesses

3.52 The legislation should prescribe eligibility requirements to act as a witness. Witnesses should be at least 18 years old, and only one witness may be a Family Member of the person accessing VAD, or a beneficiary under the person's will.

3.53 The person's Coordinating and Consulting Practitioner, and anyone who is the owner or manager of a health and/or care entity where the person is being treated, or resides, should not be permitted to witness the Formal Request.

3.54 Witnesses should be required to certify in writing that they witnessed the person signing the Formal Request, and that the person appeared to be acting freely and voluntarily.

Alternative form of Formal Request

3.55 Despite the above requirements and to acknowledge cultural preferences and promote cultural safety, the legislation may set out an alternative process for making a Formal Request, via video recording.

3.56 A Formal Request made by video recording would need to comply with a number of formalities, including (but not limited to):

(a) the Coordinating Practitioner being present to witness the recording;

(b) the person clearly identifying themselves (by providing their name and date of birth);

(c) the person declaring that:

(i) they are making a Formal Request for VAD in the presence of two witnesses and the Coordinating Practitioner;

(ii) they are making their request voluntarily and free from coercion; and

(iii) they understand the nature and effect of their request;

(d) interpreter certification, where relevant (as per 3.59 and 3.60).

3.57 The legislation should also detail witnessing requirements for Formal Requests made by video recording.

3.58 The Coordinating Practitioner should be required to submit the video recording and written documentation detailing the Formal Request to the Review Board, within two business days of the Formal Request.

Use of interpreters

3.59 The legislation should provide that in circumstances where the Formal Request is made with the assistance of an interpreter, the interpreter should be required to certify that they provided a true and correct translation of relevant materials.

3.60 To comply with certification requirements, the interpreter must also be a qualified translator.

Designated timeframe

3.61 The legislation should designate a minimum timeframe of nine days between the (accepted) First Request and the Formal Request.

3.62 The legislation should permit this requirement to be waived in circumstances where both the Coordinating and Consulting Practitioner agree that the person is likely to die or lose decision-making capacity before the end of the designated timeframe.

Use of interpreters

Policy position

3.63 The Committee adopts Recommendation 5 of the 2024 Report.

3.64 Interpreters providing interpretation services in relation to VAD must be accredited and meet other requirements specified by the Review Board.

3.65 The involvement of interpreters should be documented and reported to the Review Board at each stage of the VAD process.

Policy considerations

3.66 Throughout the VAD process, patients should have access to qualified and culturally appropriate interpreters. Recognising that access to suitable interpreters can be challenging in small First Nations communities, the Panel suggested that the development of appropriate interpreter safeguards and protocols could occur under the supervision of the Review Board. The below drafting instructions give effect to this suggestion by empowering the Review Board to approve additional interpreter requirements, and grant exemptions in special circumstances.

Drafting instructions

3.67 The legislation should set out the requirements of interpreters providing services for persons accessing VAD.

3.68 Interpreters must be accredited by a body approved by the Review Board.

3.69 Interpreters must not:

(a) be a Family Member of the person;

(b) know or believe that they will benefit financially from the person's death (including as a beneficiary under the person's will);

(c) be directly involved in the person's care; or

(d) be the owner or manager of a health or residential facility where the person is being treated or resides.

3.70 Despite the above, the legislation should provide that the Review Board may authorise an interpreter who does not meet the requirements to provide interpretation services if it is satisfied that:

(a) no other suitable interpreter is available; and

(b) there are exceptional circumstances that justify the authorisation.

3.71 At each step of the process where an interpreter is involved, the legislation should require that Authorised VAD Practitioners document and report their involvement to the Review Board. Information should include the name, contact details and accreditation details of the interpreter. Interpreters should also certify their involvement at each step.

Transfer of Coordinating Practitioner Role

Policy position

3.72 The 2024 Report does not make a recommendation about the procedure for transferring the Coordinating Practitioner's role.

3.73 The Committee recommends an approach that is consistent with the 'Australian model of VAD'.

Policy considerations

3.74 To support a person's access to VAD, a Coordinating Practitioner should be able to transfer their role at the request of the patient, or if they become unavailable.

3.75 The below model is consistent with the approach in most Australian jurisdictions.

Drafting instructions

3.76 The legislation should allow the Coordinating Practitioner's role to be transferred at the request of the patient, or because the Coordinating Practitioner is no longer available to perform the duties of the Coordinating Practitioner.

3.77 The legislation should provide that the role of Coordinating Practitioner may be transferred to the Consulting Practitioner, subject to the Consulting Practitioner:

(a) having assessed the person as eligible for VAD during a Second Assessment; and

(b) accepting the transfer.

3.78 The Consulting Practitioner must inform the Coordinating Practitioner whether they accept or refuse the transfer within two business days.

3.79 If the Consulting Practitioner accepts the transfer, the original Coordinating Practitioner must inform the patient of the transfer and submit the necessary form to the Review Board.

3.80 If the Consulting Practitioner refuses the transfer, the Coordinating Practitioner may refer the person to another medical practitioner for a further Second Assessment and then follow the transfer process outlined above.

3.81 The legislation may also provide a simple mechanism by which the original Coordinating Practitioner can resume their role at the request of the patient.

Use of telehealth

Policy position

3.82 The Committee adopts Recommendation 13 of the 2024 Report. The legislation should not prohibit the use of telehealth for the purpose of conducting VAD consultations, however, at least one of the eligibility assessments should be conducted in person.

Policy considerations

3.83 The Panel noted that while in-person consultations in the context of healthcare are generally preferred, the use of telehealth can facilitate access to VAD for Territorians living in rural and remote areas, or those unable to travel due to their medical condition. The Panel also noted that the ability to use telehealth would reduce financial and time costs of seeking VAD.

3.84 Despite the benefits of telehealth, the Panel reported on the restrictions imposed by the *Criminal Code 1995* (Cth) in relation to the use of telehealth in the context of VAD.

Drafting instructions

3.85 The legislation should provide that if it is not practicable for a patient to attend a VAD consultation in person, the consultation may occur via telehealth, subject to the requirement that one of the eligibility assessments be conducted in person.

3.86 Despite the above, telehealth is not authorised if, or to the extent that, its use would breach the *Criminal Code 1995* (Cth).[47]

47 See Katrine Del Villar et al, 'Voluntary assisted dying and the legality of using a telephone or internet service: The impact of Commonwealth 'Carriage Service' offences' (2022) 47(1) *Monash University Law Review* 125.

Chapter 4
Administration and Steps After Death

Administration Decision

Policy position

Making an Administration Decision

4.1 The 2024 Report did not include a formal recommendation about making an Administration Decision. The Committee adopts the Panel's views that:

(a) discussions about method of administration should start from the First Assessment;

(b) an Administration Decision must be able to be revoked, and a new Administration Decision made with corresponding arrangements made regarding the return and/or supply of the VAD substance(s); and

(c) the Review Board's oversight function should include notifications about Administration Decisions.

Choice of method of administration

4.2 Although not making a formal recommendation, the Panel supported a person's right to choose between Self-Administration and Practitioner Administration.[48] The Panel emphasised that safe supply, storage and disposal of the VAD substance for Self-Administration are important considerations in the NT.

4.3 The Committee supports the view that a person should be able to choose between Self-Administration and Practitioner Administration. Measures should be included in the legislation to ensure the safety of the VAD substance in the community. For example, the Committee's view is that a person seeking Self-Administration should only be supplied with one VAD kit at a time with the goal of preventing misuse of a VAD substance intended for Self-Administration.

4.4 The Committee also considers that the legislation should be framed in a way that enables a healthcare worker to be present at the time of Self-Administration if this is requested by the person seeking access to VAD.

48 2024 Report, p 72.

Policy considerations

Making an Administration Decision

4.5 Reflecting other Australian jurisdictions, a person's Administration Decision must be clear and unambiguous, and the person may communicate an Administration Decision by gesture or other means.

Choice of method of administration

4.6 Giving patients choice as to method of administration is one way to give patients more autonomous choice about the manner – including the timing – of their VAD death.[49] Over time, the Australian VAD legislative landscape has shifted to giving patients more choice about the method of administration.[50]

4.7 The drafting instructions draw on the legislative provisions in other Australian jurisdictions that favour choice but with explicit recognition of the need for safety with respect to the VAD substance as noted in the 2024 Report.[51]

4.8 The legislation in some Australian jurisdictions includes factors which are relevant to (but do not necessarily dictate) a person's choice of administration method, including the person's physical ability to self-administer the VAD substance,[52] the person's concerns about administration and the method of administration suitable for the person. These factors are included in the drafting instructions in addition to a new factor which is consideration of the safety of the VAD substance in the community.

4.9 It is important that the legislation includes a requirement that when a person revokes a Self-Administration Decision, the VAD substance must be returned and/or disposed if already supplied to the person before the person can make a new Administration Decision. This is to avoid a situation in which a person may still be in possession of a VAD substance intended for Self-Administration at the time of Practitioner Administration. The drafting instructions include a provision that the VAD kit supplied for Self-Administration must be returned where Practitioner Administration will occur, which is intended to prevent misuse of a VAD substance intended for Self-Administration.

4.10 The assessment of the appropriateness of a Self-Administration Decision should be assessed on a case-by-case basis. This assessment should be undertaken by the Coordinating Practitioner during the request and assessment process.

4.11 In some cases, a person may make a Self-Administration Decision but wish to have a healthcare worker present at the time of Self-Administration. Their role may be simply being present at the time, or assisting the person to prepare – for example, dilute or decant – the VAD substance, though the person must still self-administer the VAD substance themselves. This wish should be discussed at the time the person makes an Administration Decision. The drafting instructions include provisions which support a person's ability to have a healthcare worker present at the time of Self-Administration.

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49 Lindy Willmott and Ben White, 'Assisted dying in Australia: A values-based model for reform' in Ian Freckelton and Kerry Petersen (eds) *Tensions and Traumas in Health Law* (Federation Press, 2017) 479.

50 Whereas a default administration method is included in the legislation in Victoria, South Australia, Western Australia, Tasmania, and Queensland, in New South Wales and the Australian Capital Territory, which legalised VAD more recently, there is no default method and patients are given a choice about the administration method. States with a default administration method passed after Victoria are also generally framed to give greater discretion for practitioner administration.

51 2024 Report, pp 72-74.

52 A person's physical ability to self-administer the VAD substance may change over time, meaning that a Self-Administration Decision, once made, may need to be revoked and a new Practitioner Administration Decision made.

Drafting instructions

Making an Administration Decision

4.12 The legislation should provide a person who has completed the request and assessment process may make an Administration Decision in consultation with and on the advice of their Coordinating Practitioner. An Administration Decision can be communicated by the person to their Coordinating Practitioner verbally, by gestures, or other means.

4.13 An Administration Decision must be:

(a) made by the person (not another person on their behalf); and

(b) clear and unambiguous.

4.14 An Administration Decision must be able to be revoked by the person by communicating this to their Coordinating Practitioner verbally, by gestures, or other means. If an Administration Decision is revoked, the person must be able to make a new Administration Decision. If a person who has made a Self-Administration Decision has been supplied with a VAD kit, a new Administration Decision cannot be made until that VAD kit has been returned to an authorised disposer.

4.15 The Coordinating Practitioner and/or Administering Practitioner should notify the Review Board if a person makes or revokes an Administration Decision within two business days and include this information in the person's medical record.

Choice of method of administration

4.16 The legislation should provide that the person can choose either Self-Administration or Practitioner Administration. This decision should be made on the advice of, and in consultation with the person's Coordinating Practitioner.

4.17 An Administration Decision may only be made after specific consideration is given by the person and their Coordinating Practitioner to:

(a) the ability of the person to self-administer the substance;

(b) the person's concerns about methods of administration;

(c) the method of administration that is suitable to the person; and

(d) the ability to ensure the safe supply, storage and disposal of the VAD substance if present in the community.

4.18 A person who makes a Self-Administration Decision may request to have a healthcare worker present at the time of Self-Administration. This should be discussed when a Self-Administration Decision is made. As part of this discussion, where a healthcare worker has agreed to be present, their role should be explained to the person, including that the healthcare worker is permitted to assist in preparing the VAD substance for Self-Administration, but is not permitted to administer the VAD substance to the person.

4.19 The decision to have a healthcare worker present for Self-Administration must be documented in writing in the approved form.

Contact person

Policy position

4.20 The Committee adopts Recommendation 17 of the 2024 Report in relation to the appointment of a Contact Person for Self-Administration Decisions.

4.21 A person who has made a Self-Administration Decision must appoint a Contact Person. The responsibilities of the Contact Person relate to the supply and disposal of the VAD substance, notification of the person's death, and providing information to the Review Board.

Policy considerations

4.22 In the legislation in other Australian jurisdictions, a Contact Person, in addition to their roles with respect to return of the VAD substance and notification of the person's death, may also be contacted by the Review Board and required to provide information to the Review Board. The drafting instructions include this to assist the Review Board obtain information and perform its functions.

Drafting instructions

4.23 The legislation should provide a person who has made a Self-Administration Decision must appoint a Contact Person aged 18 years or over. This appointment should be made in the approved form and contain the prescribed information. The Coordinating Practitioner must notify the Review Board of the Contact Person appointment within two business days after receiving the appointment form.

4.24 A new Contact Person must be appointed if the original Contact Person is unable or unwilling to continue in the role.

4.25 A person who accepts the role of Contact Person must certify that they understand and accept their legal obligations as Contact Person. One of these legal obligations is to provide information if requested by the Review Board.

4.26 Within two business days of receiving the Contact Person appointment form, the Review Board must give the Contact Person information about their obligations as a Contact Person and support services available to the Contact Person in relation to their obligations.

4.27 A Coordinating Practitioner may not prescribe a VAD substance for a person who has made a Self-Administration Decision before the Contact Person appointment form has been given to the Coordinating Practitioner.

Where a person has made a Self-Administration Decision

4.28 If impracticable for the person to do so themselves, the Contact Person is legally permitted to receive, possess, handle, prepare, and supply the VAD substance to the person.

4.29 Only the person can administer the VAD substance to themselves for Self-Administration.

4.30 The Contact Person has legal obligations to:

(a) provide any unused or remaining substance to an authorised disposer;

(b) report the person's death (see further below); and

(c) provide information to the Review Board if requested.

Authorisation of VAD administration

Policy position

VAD administration permit

4.31 The Committee adopts Recommendation 16 of the 2024 Report.

4.32 Decision-making about VAD should occur between the person and their Coordinating Practitioner and not require the issuing of a permit. While not involved as 'gatekeeper',[53] the Review Board should be notified of this step.

VAD prescription

4.33 The VAD substance prescription may only be used for the purpose of VAD, must be in the approved form and include the prescribed information (included in the Regulations).

Drafting instructions

4.34 The legislation should provide that the person's Coordinating Practitioner must, within two business days of the prescription being issued, notify the Review Board that the person has been assessed as eligible for VAD, made an Administration Decision and that a VAD substance prescription has been issued.

4.35 The prescription issued for VAD must:

(a) contain a statement that:

(i) it is issued to authorise the prescription of a VAD substance;

(ii) the prescribing Coordinating Practitioner certifies that the request and assessment process has been completed for the person in compliance with the legislation;

(iii) the prescribing Coordinating Practitioner certifies that the person has made an Administration Decision (either Self-Administration or Practitioner Administration);

(iv) provides the details of the VAD substance and the maximum amount of the substance authorised by the prescription; and

(v) any other information provided by the Regulations;

53 2024 Report, p 70.

(b) be in the approved form;

(c) not provide for the VAD substance to be supplied on more than one occasion; and

(d) be given by the Coordinating Practitioner directly to an authorised supplier.

Supply, storage, and disposal of the VAD substance

Policy position

4.36 The Committee adopts Recommendation 17 of the 2024 Report in relation to the safe supply, storage, and disposal of the VAD substance.

4.37 The NT should adopt similar provisions to those in the legislation in other Australian jurisdictions regulating the supply, storage and disposal of the VAD substance.

Policy considerations

4.38 A key issue for the NT is to ensure the safe supply, storage, and disposal of the VAD substance to prevent harm to the person and the community. However, this needs to be balanced with access to VAD in a timely way. One approach briefly canvassed in the 2024 Report was to require the person or their Contact Person to collect the VAD substance from the authorised supplier at the time of Self-Administration. This is not the approach included in the drafting instructions, as requiring this may:

(a) impair the person's ability to self-administer at a time of their choosing;

(b) be onerous for the person, or Contact Person; and

(c) be impracticable given the distance and time that this may take.

4.39 While some requirements relating to the supply, storage and disposal of the VAD substance should be included in legislation, other requirements are more effectively governed by Regulations, medication protocols and/or organisation-specific guidelines.

4.40 A requirement that is important to include in the legislation is that a person should only be supplied one VAD kit at any time. This means that where a Self-Administration Decision is revoked, if the VAD substance for Self-Administration has already been dispensed, it must be returned and/or disposed of before a new Practitioner Administration Decision can be made. Drafting instructions to this effect are included at paragraph 4.14 above.

4.41 Prescription is an important part of the administration process that happens after the Administration Decision, and before the substance is supplied. It is important that the prescription process is included in the legislation as a further safeguard and opportunity for the Review Board to be notified about individual cases.

4.42 The prescription and supply processes provide important opportunities for the person and others to be informed about administration. In the case of the person, receiving this information is vital to ensure informed consent in relation to administration. The drafting instructions below, consistent with the legislation in other Australian jurisdictions, reflect points at which important information should be provided.

Drafting instructions

4.43 The legislation should provide for the following definitions:

(a) authorised supplier – registered health practitioner(s) authorised to supply VAD substances by the CEO; and

(b) authorised disposer – registered health practitioner(s) authorised to dispose of VAD substances by the CEO.

4.44 Regulations and other protocols will be developed in relation to the prescription, supply, storage and disposal of the VAD substance and these must be adhered to throughout the administration process.

4.45 The person must be given written information about the VAD substance and other matters relevant to administration – including how to self-administer and store the substance (if appropriate) and the expected effects and risks of administration – before the Coordinating Practitioner can prescribe a VAD substance and after the person has made an Administration Decision.

4.46 The authorised supplier must authenticate the prescription before the VAD substance can be dispensed and supplied. The authorised supplier must not dispense the prescription unless they have confirmed the validity of the prescription, the identity of the person who issued the prescription, and the identity of the person to whom supply of the VAD substance is being made.

4.47 In the case of Self-Administration, the person to whom the VAD substance is being supplied should be given information by the authorised supplier.

4.48 Relevant persons (the Coordinating Practitioner, authorised supplier, the person, the Contact Person, another person who may be present at the time of Self-Administration, and the Administering Practitioner) must have relevant authorisations after an Administration Decision is made (to allow prescribing, receiving, possessing, preparing, and supplying the VAD substance to the person, as relevant). Only the person themselves is authorised to self-administer the VAD substance.

4.49 Where a person has made a Self-Administration Decision, the person must ensure that the VAD substance is stored in a safe and secure way, according to the Regulations.

4.50 The Contact Person is responsible for returning the VAD substance to a person authorised to dispose of the VAD substance (authorised disposer) within two business days where the person has:

(a) died prior to Self-Administration;

(b) revoked a Self-Administration Decision; or

(c) self-administered the VAD substance (in case there is any remaining or unused).

4.51 Both the Administering Practitioner and authorised disposer must safely dispose of unused or remaining VAD substances as soon as practicable.

Notifications relating to prescription, supply, and disposal

4.52 The Review Board must be notified in the approved form at each step in the prescription, supply and disposal processes by the relevant person within two business days of each step.

Administration of the VAD substance

Policy position

4.53 The 2024 Report does not make recommendations about the procedure for, or witnessing of, Practitioner Administration. The Committee considers that these procedures should be included in the legislation.

Policy considerations

4.54 Including the procedure for Practitioner Administration in the legislation may protect the person and the Administering Practitioner. The drafting instructions below include proposals for this procedure (and are based on the legislation in other Australian jurisdictions).

Drafting instructions

4.55 In relation to a person who has made a Practitioner Administration Decision, the legislation should provide for a definition of an eligible witness to Practitioner Administration – a person who:

(a) has reached 18 years of age; and

(b) is not an ineligible witness. A person is an ineligible witness if they:

(i) are a Family Member of the Administering Practitioner for the person; or

(ii) are employed or engaged under a contract for services, by the Administering Practitioner for the person.

4.56 An eligible witness must be present when a VAD substance is administered. Following administration, the witness must certify in the approved form that the person was acting voluntarily and without coercion and the Administering Practitioner administered the VAD substance to them in the presence of the witness.

4.57 An Administering Practitioner who has administered a VAD substance to a person who made a Practitioner Administration Decision must certify in writing, immediately following administration that:

(a) the person made a Practitioner Administration Decision, and did not revoke that decision;

(b) the Administering Practitioner was satisfied at the time of administration that the person had decision-making capacity in relation to VAD; and

(c) the person was acting voluntarily and without coercion.

4.58 Both certifications must be provided to the Review Board within two business days of administration.

Death notification and certification

Policy position

4.59 The Committee adopts Recommendation 18 of the 2024 Report.

4.60 The Review Board must be notified of the deaths of persons who accessed VAD.

4.61 The Review Board or others are not generally required to notify the Coroner about VAD deaths except in specific circumstances.

4.62 The death certificate or other cause of death certification for a person must not state that the person's death was as a result of VAD.

Policy considerations

4.63 That VAD deaths are not generally considered a 'reportable death' for the purposes of the Coroner's Act is consistent with the *ROTI Act.*

4.64 The 2024 Report considered that while the Coroner should not be notified of all VAD deaths, they should be notified about cases where: the certification and notification requirements of the legislation were not complied with, there is a suspicion that the person did not meet all of the eligibility requirements, and there were complications arising from administration of the VAD substance.

4.65 The Committee does not wholly adopt this view of the Panel in the 2024 Report. This is because notifying the Coroner about:

(a) 'cases in which the certification and notification requirements of the legislation were not complied with' may result in a high volume of notifications to the Coroner about minor instances of non-compliance; and

(b) 'complications arising from administration of the VAD substance' may lead to a high volume of notifications for non-significant issues as the term 'complications' could include a wide range of potential outcomes.

4.66 In addition, the proportion of Review Board members who suspect that a person did not meet all of the eligibility requirements before referral to the Coroner or another body can be made, should be included in the legislation. This issue is addressed in the discussion of the functioning and referral powers of the Review Board in Chapter 7 of these drafting instructions.

4.67 The drafting instructions reflect that the Review Board is best placed to manage and respond in cases of non-compliance or complications being experienced. The Review Board will be empowered to exercise its discretion to refer cases to the Coroner or other appropriate body in the event of major or significant instances of non-compliance or complications (see Chapter 7).

Drafting instructions

Notification of death

4.68 Within two business days of becoming aware of the person's death, the Contact Person must notify the Coordinating Practitioner about the death of the person where the person has:

(a) died prior to Self-Administration; or

(b) self-administered the VAD substance.

4.69 The Coordinating Practitioner and Administering Practitioner must notify the Review Board of the death of the person, whether they died following the administration of a VAD substance or from another cause within two business days after becoming aware the person has died.

Death certificate or other cause of death certification

4.70 If a medical practitioner who is required to give a cause of death certificate for a person knows or reasonably believes that the person self-administered or was administered a VAD substance they must, within two business days after becoming aware of the person's death, notify the Review Board in the approved form of the person's death (unless they are the person's Coordinating Practitioner or Administering Practitioner so have already done so).

4.71 The death certificate or other cause of death certification for a person who died following administration of a VAD substance must not state that the person's death was a result of, or caused by, VAD. Instead, the cause of death must be nominated as the underlying eligible illness, disease or medical condition.

Notification to the Coroner

4.72 The legislation should provide the death of a person who has accessed VAD is not a reportable death for the purposes of the *Coroners Act 1993* (NT).[54]

54 It is beyond the scope of these instructions to consider interactions between potential NT VAD legislation and other NT or federal legislation. However, the reference to this NT Act is included as it relates to a specific recommendation in the 2024 Report.

Transfer of Administering Practitioner role

Policy position

4.73 The 2024 Report does not make a recommendation about the procedure for transferring the Administering Practitioner's role. The Committee considers that this procedure should be included in the legislation.

Policy considerations

4.74 The ability of an Administering Practitioner to transfer their role if they become unavailable helps facilitate access to Practitioner Administration for the person.

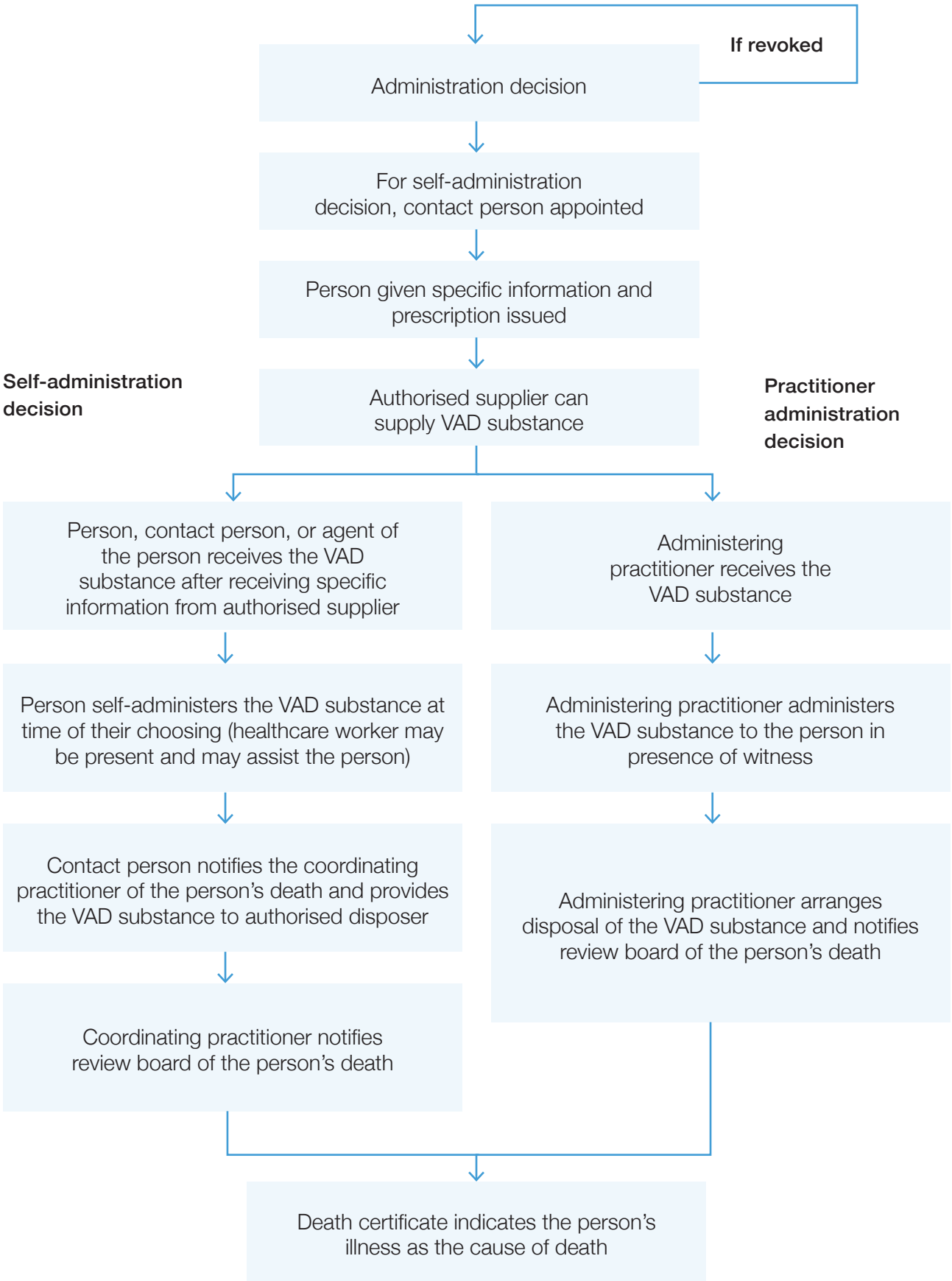
Drafting instructions

4.75 The legislation should provide that the Administering Practitioner can transfer their role to another Authorised VAD Practitioner willing and able to act in the role for the person.

4.76 The person and the Review Board (within two business days) should be notified of the transfer. The transfer should also be recorded in the person's medical record.

4.77 The original Administering Practitioner must provide the new Administering Practitioner with the VAD substance (if already in their possession).

Diagram of key steps for administration and steps after death



Chapter 5
Health Practitioner Requirements

Coordinating and Consulting Practitioners

Policy position

5.1 The Committee adopts Recommendation 3 of the 2024 Report.

Qualifications: Prescribed period of registration as medical practitioner

5.2 Medical practitioners acting in the role of Coordinating or Consulting Practitioner should have a minimum period of registration. This requirement balances supporting equity and access to VAD while ensuring safeguards (such as appropriate qualifications) are in place.

Training requirements

5.3 All health practitioners should undertake mandatory training before providing VAD services. The training should include content about legislative processes, ethical content, communication skills and supporting cultural beliefs and practices surrounding end-of-life care for Aboriginal and Torres Strait Islander Peoples.

Policy considerations

Qualifications: Prescribed period of registration as medical practitioner

5.4 The 2024 Report concluded that overly prescriptive requirements for specialist registration would severely hinder access due to the limited number of specialist medical practitioners in the NT and requirements for face-to-face assessments. Additional requirements to have expertise in end-of-life care were considered but should not be legislated due to likely impacts on access. Additional requirements for practitioners may also be imposed by the CEO.

Training requirements

5.5 Requiring VAD practitioners to undertake approved mandatory training before providing VAD services is a safeguard that ensures a required standard of knowledge and consistent decision-making in accordance with the NT VAD legislation.[55]

5.6 The 2024 Report concluded the training requirements for NT VAD practitioners should be unique. Content about ethical considerations and communication skills to support practitioners involved in the VAD process should be included in the training in addition to the legal and compliance aspects of VAD.

5.7 Also, VAD practitioners should be trained about cultural beliefs and practices surrounding end-of-life care for Aboriginal and Torres Strait Islander Peoples.

5.8 Reflecting the approach in other jurisdictions, the CEO should have authority to approve the required content of the mandatory training.[56]

Drafting instructions

Prescribed period of registration

5.9 Coordinating and Consulting Practitioners must be qualified medical practitioners with at least five years general registration, or one year of specialist registration.

5.10 Coordinating and Consulting Practitioners must meet the approved medical practitioner requirements as determined by the CEO.

Training requirements

5.11 The legislation should provide that Coordinating and Consulting Practitioners must have completed the mandatory training before providing VAD services.

5.12 The content of the mandatory training must be approved by the CEO.

Other requirements: Exclusions

5.13 The legislation should provide that the Coordinating or Consulting Practitioner may not be a Family Member of the person requesting access to VAD.

5.14 The legislation should provide that the Coordinating or Consulting Practitioner may not be a beneficiary under the will of the person accessing VAD and will not otherwise benefit financially from the person's death.

55 Ben White et al, 'Development of Voluntary Assisted Dying Training in Victoria, Australia: A Model for Consideration' (2021) 36(3) *Journal of Palliative Care* 162.

56 See *Voluntary Assisted Dying Act 2019* (WA) s 160; *Voluntary Assisted Dying Act 2021* (QLD) s 165; *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (TAS) s 117.

Administering Practitioners

Policy position

Value of the role of Administering Practitioners

5.15 Creating the role of Administering Practitioner, including expanding the categories of health practitioners that can act in this role, will enhance access to VAD and alleviate the potential strain on participating medical practitioners.

Training requirements

5.16 The training requirements for Administering Practitioners should be the same as for Consulting and Coordinating Practitioners.

Policy considerations

Which practitioners can be Administering Practitioners

5.17 Enabling nurse practitioners and registered nurses to be Administering Practitioners will allow more practitioners to administer VAD, increasing access to VAD and alleviating the potential strain on Coordinating Practitioners.

5.18 Where the Administering Practitioner is a different person from the Coordinating Practitioner, the Administering Practitioner will have obligations to ensure they are satisfied that all preceding steps in the process have been met.

Training requirements

5.19 Administering Practitioners should undertake mandatory training before participating as an Administering Practitioner.

Drafting instructions

Prescribed period of registration

5.20 Administering Practitioners must be a qualified medical practitioner, a nurse practitioner, or a registered nurse who has practised in the nursing profession for more than 5 years.

5.21 Administering Practitioners must meet the approved practitioner requirements as determined by the CEO.

Training requirements

5.22 The legislation should require Administering Practitioners to have completed the standard mandatory training before being able to undertake the role of Administering Practitioner.

Other requirements: Exclusions

5.23 The legislation should provide that the Administering Practitioner may not be a Family Member of the person requesting access to VAD.

5.24 The legislation should also provide that the Administering Practitioner may not be a beneficiary under the will of the person accessing VAD and will not otherwise benefit financially from the person's death.

Chapter 6
Non-Participation by Health Practitioners and Entities

Non-participation by health practitioners

Policy position

6.1 The Committee adopts Recommendation 4 of the 2024 Report, as it relates to the participation of individual health practitioners.

6.2 Health practitioners who conscientiously object to VAD should be able to choose not to participate in VAD.

6.3 This right of health practitioners should not impede or hinder the ability of people to access VAD.

6.4 Health practitioners who choose not to participate in VAD on the basis of a conscientious objection should be required to give the person information about another health practitioner or health service who can assist or provide the contact details of the VAD navigator service.

Policy considerations

6.5 The right of health practitioners to conscientiously object to providing or being involved with VAD services is specifically recognised in all Australian jurisdictions. In some of those jurisdictions, practitioners are required either to refer the person to another practitioner or service that is likely to be able to provide VAD or provide specified information to the person (generally the contact details of the VAD navigator service).

6.6 The Panel noted that while health practitioners should not be required to participate in VAD, there is a community expectation that objecting practitioners should not impede access and should support patients to connect with another health practitioner or health service who can assist.

6.7 The Panel did not specifically consider which group of practitioners these rights and obligations should apply to. While provisions relating to conscientious objection generally only apply to registered health practitioners in other Australian jurisdictions, the Committee considered that this statutory right to conscientious objection should be more widely available to include a broader range of persons who provide or support the provision of health or care services. The below drafting instructions give effect to this position with the required flexibility about who is captured by the term ‘relevant person involved in providing or supporting the provision of health or care services’ to be established in Regulations.

Drafting instructions

6.8 The legislation should provide that a 'relevant person involved in providing or supporting the provision of health or care services' who conscientiously objects to VAD may refuse to participate or be involved in VAD.

6.9 A 'relevant person involved in providing or supporting the provision of health or care services' who conscientiously objects to VAD should have a right to refuse to do any of the following:

(a) provide information about VAD;

(b) participate in the request and assessment process;

(c) participate in an Administration Decision;

(d) prescribe, supply or administer a VAD substance; and

(e) be present at the time of administration of a VAD substance.

6.10 A 'relevant person involved in providing or supporting the provision of health or care services' who, because of a conscientious objection, refuses to participate in any of the steps noted in paragraph 6.9 for a person seeking information or assistance in relation to VAD, must:

(a) inform the person that a health practitioner or health service may be able to assist the person; and

(b) give the person:

(i) information about a health practitioner or health service that is likely to be able to assist the person; or

(ii) the contact details of the official VAD navigator service.

6.11 Despite the above, medical practitioners must comply with the obligations in relation to a First Request (see paragraphs 3.15 and 3.16).

Participation by health or care entities

Policy position

6.12 The Committee does not adopt Recommendation 4 of the 2024 Report that relates to the obligations of residential facilities in relation to VAD.

6.13 The Committee's view is that while no health or care entity should be required to participate in VAD, they must allow access to information onsite and refer persons who seek information about VAD to the official VAD navigator service. Those entities must also facilitate any requested transfers for a person to and from a location to access any step in the VAD process.

6.14 The Committee supports the suggestion of the Panel in the 2024 Report that the legislation should include provisions requiring health or care entities which object to participating in VAD to advertise or communicate their objection to others.[57]

57 2024 Report, p 41.

Policy considerations

Policy decision to include obligations in legislation

6.15 The first three Australian jurisdictions to pass VAD legislation (Victoria, Western Australia and Tasmania) were silent on the obligations of health or care entities in relation to VAD hence this issue has been left to be regulated in policy. The four jurisdictions that followed (South Australia, Queensland, New South Wales and the Australian Capital Territory) have specifically addressed this issue in their VAD legislation.

6.16 The drafting instructions propose that the issue of a person's access to VAD in a health or care entity be regulated in legislation. Including obligations in the legislation provides direction and certainty in relation to the relative rights and responsibilities of health or care entities and people seeking access to VAD.[58] Policy-only responses in other states have been reported to have caused challenges in practice.[59] Policy will also be needed in the NT to provide practical guidance on entities' obligations within the framework provided by the legislation.

Obligations on health or care entities

6.17 Health or care entities are permitted to object to providing VAD across Australia. However, entities have responsibilities under the legislation in South Australia, Queensland, New South Wales and the Australian Capital Territory to facilitate a person's access to VAD and information about VAD. Though these laws vary, entities are generally required either to allow access to information or a step in the VAD process onsite or facilitate the transfer of the person to another location to access that step in the VAD process. Which steps a person can or cannot access onsite generally depends on whether the person is a permanent resident in the health or care entity.[60] This difference reflects a policy decision that for a permanent resident, the facility is the person's home, and the person should not have to leave their home to access this end-of-life choice.[61] The Australian Capital Territory does not adopt the policy distinction between permanent residents and non-permanent residents and grants rights to access VAD regardless of residency status.

6.18 The Committee's view is that health or care entities should be permitted to object to VAD occurring onsite. This is because VAD occurring onsite may conflict with or contradict an entity's values, purpose or mission, and raise concerns about the ability of an entity to provide culturally safe care for First Nations people. However, objecting entities must not hinder a person's access to information about VAD, must allow access to a VAD care navigator onsite, and must provide a requesting person with the contact details of the official VAD navigator service. They must also facilitate any requested transfers for a person to and from a location where this may be needed to access any step in the VAD process.

6.19 The Committee also considers that health or care entities which object to participating in VAD should advertise or communicate their objection to others so they are aware of that position and can make informed decisions accordingly.

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58 Ben P White, Lindy Willmott and Eliana Close, 'Legislative Options to Address Institutional Objections to Voluntary Assisted Dying in Australia' [2021] (3) *University of New South Wales Law Journal Forum* 1, 14.

59 Ben P White et al, 'The Impact on Patients of Objections by Institutions to Assisted Dying: A Qualitative Study of Family Caregivers' Perceptions' (2023) 24(1) *BMC Medical Ethics* 22.

60 Permanent residents of an entity are people for whom the entity is their settled place of abode and where they customarily live: *Voluntary Assisted Dying Act 2021* (Qld) s 89.

61 Katherine Waller et al, 'Voluntary Assisted Dying in Australia: A Comparative and Critical Analysis of State Laws' (2023) 46(4) *University of New South Wales Law Journal* 1421, 1457.

Drafting instructions

6.20 The legislation should provide a definition of health or care entity or other term that covers health entities providing health and/or care services including: public and private hospitals; hospices; and residential aged care facilities, nursing homes or other facilities at which care is provided to persons who, because of infirmity, illness, disease, incapacity or disability, have a need for nursing or personal care.

Notifications about VAD

6.21 All health or care entities which do not participate in VAD must:

(a) advertise this position publicly in a way that is likely to be accessed by prospective residents and/or patients; and

(b) notify persons in the health or care entity (including residents and patients) who express a wish to access VAD of this position.

Obligations to refer and allow access to information

6.22 The following provision applies if a person is receiving relevant services (a health service, residential aged care or a personal care service) from a health or care entity and the person asks for information about VAD and the entity does not provide the requested information.

6.23 The health and care entity:

(a) must provide the person with the contact details of the official VAD navigator service;

(b) must not hinder the person's access at the health or care entity to information about VAD; and

(c) must allow reasonable access to the person at the health or care entity by a member or employee of an official VAD care navigator service.

6.24 A health or care entity must not prevent or prohibit an employee or healthcare worker onsite from initiating conversations about VAD or otherwise providing information about VAD to persons in accordance with the legislative provisions described in paragraphs 3.4-3.8 of Chapter 3.

Obligations to facilitate transfers

6.25 These provisions apply if a person or the person's agent advises the health or care entity that the person wishes to undergo a step in the VAD process and the entity does not wish to allow this to occur onsite. Relevant steps in the VAD process include:

(a) making a First or Formal Request for VAD;

(b) undergoing a First Assessment or a Second Assessment for VAD;

(c) making an Administration Decision; and

(d) administering the VAD substance.

6.26 The health or care entity must take reasonable steps to facilitate the transfer of the person to (and from, if required) a place where the relevant step in the VAD process may be carried out by a health practitioner who is able to facilitate this step for the person.

Chapter 7
Accountability, Offences and Protections

Review Board

Policy position

7.1 The Committee agrees with Recommendation 19 of the 2024 Report that the VAD system should have a Review Board. The Board should be established by the legislation and chaired by the CHO.

7.2 The Board's functions should include:

(a) monitoring the NT's VAD system;

(b) oversight of individual VAD cases to ensure compliance; and

(c) reviewing the operation of the NT's VAD legislation.

Policy considerations

7.3 While the 2024 Report does not make a formal recommendation about the Board's membership, it identifies that it should include cultural expertise and diversity, geographical and regional representation (which may include mandating that at least one health practitioner member must be practising in Central Australia) as well as an Aboriginal person to provide guidance in relation to Aboriginal culture and traditions.[62]

7.4 The Committee's view is that the Board should be chaired by the CHO and include other members with clinical, legal, and cultural expertise or experience.

7.5 The 2024 Report identifies that the functions and powers of the Board should generally be consistent with those of the Queensland VAD Review Board included in Queensland's legislation,[63] and include some additional functions such as facilitating the future statutory review of the NT legislation.

62 2024 Report, p 78.

63 2024 Report, p 79; the Report states a number of matters that should specifically be included in the Review Board's functions and powers including: providing for referrals to other entities such as the Police Commissioner; requesting information from the CEO of the Department of Health and any accredited person providing any aspect of a VAD service (including interpreting, bereavement support or chaplaincy); and requesting information from a Contact Person or a treating medical practitioner of an eligible person. Each of these functions are possible under the Queensland legislation's functions and powers of the Review Board (so are encompassed in the proposed drafting instructions).

7.6 The 2024 Report does not make a formal recommendation about data collection and sharing by the Board. It identifies the importance of collecting information about the VAD process for a range of purposes including monitoring compliance and supporting the functions of the Board.[64]

7.7 The Committee's view is that while the Board will be notified about individual VAD cases via the submission of approved forms from the beginning of the VAD process, its obligation to review cases for compliance with the law should apply to cases in which a person who has been assessed as eligible for VAD has died following administration of a VAD substance or another cause.

Drafting instructions

7.8 The NT legislation should establish a Review Board for VAD in the NT.

7.9 The legislation should provide a definition of a 'completed case' – where a person who has been assessed as eligible for VAD following a First Assessment and a Second Assessment has died whether following administration of a VAD substance or another cause.

7.10 The Board should have the following functions, and the powers necessary to give effect to these functions:

(a) to monitor the operation of the NT VAD legislation;

(b) to review each completed case including for whether the NT legislation was complied with by the relevant person(s) in each case;

(c) to refer to the relevant entities, issues identified by the Board in relation to VAD, including suspected non-compliance, including:

(i) the Police Commissioner;

(ii) the Australian Health Practitioner Regulation Agency;

(iii) the Coroner;

(iv) the Aboriginal Health Service;

(v) the CEO of the Department of Health; or

(vi) the Health and Community Services Complaints Commission;

(d) to collect, record, use and keep data and information about requests for and provision of VAD (including information prescribed by Regulation) and disclose this information where appropriate or required for the purposes of performing its functions;

(e) to analyse information given to the Board under the NT legislation and to research or facilitate research of matters related to the operation of the NT legislation;

(f) to provide, on the Board's own initiative or on request, information, reports and advice to the Minister or CEO of the Department of Health in relation to:

(i) the operation of the NT legislation;

(ii) the Board's functions; or

(iii) the improvement of the process and safeguards of VAD;

64 2024 Report, p 80.

(g) to promote compliance with and understanding of the NT legislation, including by providing information and resources about the operation of the legislation to registered health practitioners and community members;

(h) to oversee the setting of standards for health practitioner experience and practice, training and qualification requirements and interpreter requirements and exemptions;

(i) to promote continuous improvement in the compassionate, safe and practical operation of the NT legislation;

(j) to consult and engage with the community and any entity the Board considers appropriate in relation to VAD;

(k) to facilitate the statutory review of the NT legislation;

(l) to oversee the development and implementation of clinical guidelines relating to VAD processes; and

(m) any other function given to the Board in the NT VAD legislation.

7.11 The Board must provide information at regular intervals to the Coroner, including the number of completed cases.

7.12 The Board's powers must enable it to request information for the purpose of exercising its functions from:

(a) the CEO of the Department of Health;

(b) any person – accredited or otherwise – participating in VAD provision including people providing such services as interpreting, bereavement support or chaplaincy;

(c) a Contact Person appointed for a person seeking access to VAD; and

(d) a treating medical practitioner of an eligible person.

7.13 The Board must act independently and in the public interest. The Board is not subject to direction by anyone, including the Minister, about how it performs its functions.

7.14 The CEO of the Department of Health must ensure the Board is provided with the staff, services and facilities, and other resources and support, that are reasonably necessary to enable the Board to perform its functions.

Membership of the Review Board

7.15 The Minister, on the recommendation of the CHO, must ensure the membership of the Board:

(a) includes persons with a range of experience, knowledge and skills relevant to the Board's functions which may include clinical, legal, ethical, and cultural expertise; and

(b) takes into account the social, cultural and geographic/regional characteristics of the NT community and reflects this diversity.

7.16 At a minimum, the Board must consist of:

(a) the CHO (or a person with delegated authority to act with the powers of the CHO) (see further below);

(b) one member who has clinical (including medical or nursing) expertise;

(c) one member who has legal expertise;

(d) one member who is an Aboriginal person in a position to provide and seek advice from First Nations peoples in relation to cultural matters relating to VAD; and

(e) one member who is employed by or a representative of an Aboriginal Community Health Organisation in the NT.

7.17 The CHO is the Chairperson of the Board and is responsible for leading and directing the activities of the Board to ensure it performs its functions appropriately. The CHO is permitted to delegate the role of Chairperson to a person with delegated authority to act with the powers of the CHO.

7.18 A Deputy Chairperson should be appointed to act in the role of Chairperson during a vacancy in the office, or absence of the Chairperson.

7.19 In the event that the Board requires expert advice in relation to cultural matters, including cultural safety, the Board should seek the required advice from the relevant people.

Other provisions

7.20 Other provisions should also be included relating to:

(a) the membership and roles of the Board;

(i) the roles and responsibilities of the Board's Chairperson and Deputy Chairperson;

(ii) term of appointment for members;

(iii) appointment and reappointment of members;

(iv) vacation of office;

(v) persons unable to be appointed as members;

(vi) conditions of appointment;

(b) the proceedings of the Board, including conduct of meetings, disclosure of interests and the voting of members on referrals to relevant entities in paragraph 7.10(c), above;[65] and

(c) miscellaneous provisions.[66]

65 Reference could be had to Part 8 Division 3 of the *Voluntary Assisted Dying Act 2021* (Qld) in relation to these provisions.

66 Reference could be had to Part 8 of the *Voluntary Assisted Dying Act 2021* (Qld) in relation to these provisions.

Reporting

7.21 The Board must provide an Annual Report to the Minister reporting on the performance of the Board's functions within the financial year within six months of the end of the financial year. This report must include:

(a) information on the operation of the NT legislation including the number of completed cases of which the Board has been notified in the financial year;

(b) recommendations of the Board relevant to the performance of its functions, including recommendations about systematic matters in VAD or the improvement of VAD; and

(c) a de-identified summary of the information required to be collected and kept by the Board under paragraph 7.10(d), above.

7.22 The Minister must table a copy of the Annual Report in the Legislative Assembly within 14 sitting days after receiving it.

Appeal Mechanisms

Policy position

7.23 The NTCAT should have jurisdiction to review the following decisions made in the VAD process:

(a) whether a person meets the residence requirements (including eligibility for exemption);

(b) whether the person has decision-making capacity in relation to VAD; and

(c) whether the person is acting voluntarily and without coercion.

7.24 The Committee proposes following the Australian model to allow the person seeking VAD and a limited group of other people to apply for review of these decisions.

7.25 The inherent jurisdiction of the Supreme Court to hear cases relating to VAD should be preserved.

Policy considerations

7.26 The Committee recognises that the recommendation in the 2024 Report that only the person seeking access to VAD (the person subject of the reviewable decision) can apply for review of decisions departs from the Australian model. The 2024 Report reached this view based on concerns that an external review process could be used by others to unfairly prevent a person from choosing to access VAD. In the other Australian jurisdictions, a wider range of persons are permitted to seek review, including an agent of the person or another person who has a relevant interest in the person seeking access.

7.27 The Committee's view is that an agent of the person should also be permitted to apply for review of a reviewable decision. The agent of the person is someone the person appoints to act on their behalf if the person is unable to apply for the review themselves. Permitting an agent to apply for review extends the ability of the person affected by the decision to seek review if they are too unwell to do so.

7.28 In Victoria, Western Australia and Tasmania, another person whom the Tribunal or Commission is satisfied has a special interest in the medical treatment and care of the person can also apply for review of a reviewable decision. In Queensland and New South Wales, a person who has sufficient and genuine interest in the rights and interests of the person is eligible to seek review of a reviewable decision. Including this third category of 'interested persons' may permit a member of the person's healthcare team, a family member or carer to seek review of a decision and in so doing act in the interests of the person. For instance, a medical practitioner may seek review of their own assessment with respect to the person's ineligibility as part of exploring whether, in fact, the person should be eligible on this basis; an example is if the medical practitioner believes a person does not meet residency requirements but are not sure. Acknowledging the concerns about people inappropriately attempting to block a person's access to VAD, the NTCAT could be granted responsibility for deciding whether any person falls into this third category of interested persons. For this reason, the drafting instructions below propose that this third category of person is included as eligible to seek review in the legislation.

Drafting instructions

Definitions

7.29 Definitions relevant to the following proposed legislative content, including definitions of:

(a) reviewable decision:

(i) whether a person meets the residence requirements (including eligibility for exemption);

(ii) whether the person has decision-making capacity in relation to VAD; and

(iii) whether the person is acting voluntarily and without coercion;

(b) eligible person:

(i) person who is subject of the decision;

(ii) their agent;

(iii) the Coordinating or Consulting Practitioner for the person; or

(iv) any other person who the NTCAT considers has sufficient and genuine interest in the rights and interests of the person subject of the decision in relation to VAD.

7.30 An eligible person can apply to NTCAT to seek review of a reviewable decision.

7.31 The effect of making an application is that the VAD process is suspended and no further steps may be taken until the application is finalised, withdrawn (including if the person dies), or dismissed.

7.32 If the NTCAT's decision is that the person:

(a) does meet the residence requirements;

(b) has decision-making capacity in relation to VAD; or

(c) is acting voluntarily and without coercion;

the effect of NTCAT's decision is that the VAD process is no longer suspended and if the reviewable decision is to be set aside, the NTCAT's decision replaces the reviewable decision.

7.33 If the NTCAT's decision is that the person:

(a) does not meet the residence requirements;

(b) does not have decision-making capacity in relation to VAD; or

(c) is not acting voluntarily and without coercion;

the effect of the NTCAT's decision is that the person is ineligible for VAD, the VAD process ends and no further steps in the VAD process can be taken.

7.34 The NTCAT should provide a written statement of reasons for the decision made in relation to a review of a reviewable decision.

7.35 The legislation should also provide for other procedural provisions relating to the conduct of reviews by NTCAT in relation to VAD.[67]

7.36 Nothing in the NT legislation affects the inherent jurisdiction of the Supreme Court.

Review of the legislation

Policy position

7.37 The NT VAD legislation should be reviewed three years after its commencement and thereafter every five years.

Policy considerations

7.38 The 2024 Report does not include a formal recommendation about specific matters that must be considered as part of the first and subsequent reviews of the legislation. The drafting instructions propose including some specific matters to be considered during the reviews, and provide an opportunity to consider the eligibility criteria included in the legislation.

Drafting instructions

7.39 The Minister must review the operation and effectiveness of the NT's legislation as soon as practicable:

(a) three years after the day of its commencement (the first review); and

(b) every five years after the first review of the NT legislation is presented to the Legislative Assembly.

7.40 The review must include consideration of:

(a) the principles set out in the NT VAD legislation;

(b) the eligibility criteria; and

67 Reference could be had to Part 7 Divisions 3-4 of the *Voluntary Assisted Dying Act 2021* (Qld).

(c) whether the legislation is operating as intended.[68]

7.41 As soon as practicable after finishing the review, the Minister must table a report about its outcome in the Legislative Assembly.

Contraventions and Offences

Policy position

7.42 There are no formal recommendations in relation to contraventions and offences in the 2024 Report.

7.43 The 2024 Report provides limited information about the scope of offences and contraventions to be included in the legislation.

7.44 However, it notes that the imposition of heavy sanctions for serious criminal offences and appropriately weighed penalties for lesser contraventions will promote compliance with the legislation.

7.45 It also notes that certain conduct may lead to disciplinary breaches under the Health Practitioner National Law.

7.46 The below drafting instructions briefly detail offences that should be included in the legislation, consistent with the 'Australian model of VAD'. They do not classify the offences or suggest appropriate penalties.

Drafting instructions

7.47 The legislation should create new offences about non-compliance with the legislation.

7.48 Certain offences will apply to 'any person' while other offences will apply to those who have a specified role under the legislation.

7.49 Serious offences which apply to 'any person' should include:

(a) unauthorised administration of a VAD substance;

(b) inducing a person to request VAD; and

(c) inducing a person to self-administer a VAD substance.

68 2024 Report, p 82.

7.50 Serious offences which apply to persons who participate in the VAD process should include:

(a) knowingly providing false or misleading information about VAD to the Review Board;

(b) knowingly making a false or misleading statement on a document required to be made under the legislation;

(c) falsifying documents; and

(d) recording, using or disclosing personal information obtained in the course of exercising a function under the legislation, unless this is done:

(i) for a purpose under the legislation;

(ii) with the relevant person's consent; or

(iii) as authorised or required by law.

7.51 The legislation should also create offences relating to non-compliance with the procedural requirements of the legislation, including:

(a) a health practitioner performing a function under the legislation failing to submit the required forms with the specified timeframe; and

(b) a contact person failing to return the unused VAD substance within the specified timeframe.

Protections

Policy position

7.52 The 2024 Report did not make specific recommendations in relation to indemnifying participants in the VAD process but observed these provisions are essential in ensuring the practical workability of the VAD legislation.

7.53 VAD legislation should contain provisions protecting health practitioners and others from liability (criminal, civil and/or professional) for their participation in the VAD process in accordance with the legislation.

Drafting instructions

7.54 The legislation should provide a person will not be criminally, civilly or professionally (as relevant) liable for:

(a) assisting another person who makes a request to access VAD;

(b) being present when another person self-administers or is administered a VAD substance;

(c) acting in accordance with the legislation; or

(d) providing information to the Review Board in accordance with the legislation.

7.55 Health practitioners will not be criminally, civilly or professionally (as relevant) liable for referring a patient who requests VAD services to another health practitioner.

7.56 Health practitioners or others who would normally have a duty to administer life sustaining treatment will not be criminally, civilly or professionally (as relevant) liable for refraining from administering life sustaining treatment where:

(a) they believe on reasonable grounds that the person is dying after administering the VAD substance; and

(b) the person does not request life sustaining treatment.

7.57 The legislation should also provide that nothing in this section prevents a person from making a mandatory or voluntary complaint about a person to any relevant oversight body.

Miscellaneous

7.58 We note that a number of other issues are typically addressed outside the substantive parts of VAD legislation. These 'miscellaneous' provisions include, but are not limited to:

(a) recognising that a technical error on a form, request, notice or documentation, does not invalidate the form, request, notice or documentation or affect any part of the VAD process;

(b) notifications under the Health Practitioner Regulation National Law;

(c) empowering the CEO to authorise:

(i) an official VAD navigator service;

(ii) substance suppliers and disposers;

(iii) a VAD substance;

(iv) VAD practitioner requirements;

(v) approved information;

(vi) approved training; and

(vii) approved forms;

(d) the scope and purpose of Regulations made under the legislation; and

(e) the requirement of the Review Board to notify practitioners when a form has been received.

Chapter 8
Other Considerations

8.1 If VAD is legalised in the NT, additional regulation and policy will need to be established to support a safe and accessible VAD system. This chapter briefly discusses some of these matters including Regulations, CEO requirements, medication protocols and professional guidance and training. The chapter also provides some observations about the implementation of VAD in other Australian jurisdictions.

Regulation of VAD beyond the legislation

Regulations

8.2 The NT may consider establishing VAD Regulations to support the administration of the VAD system. Regulations exist in Tasmania, South Australia, Queensland, Victoria and the Australian Capital Territory. While the scope of the Regulations varies significantly between jurisdictions, some key areas relevant to the proposed NT model include:

(a) the prescribed forms to be used in the VAD process;

(b) accreditation requirements for interpreters;

(c) secure storage specifications for the VAD substance;

(d) requirements for prescribing the VAD substance;

(e) labelling requirements for the VAD substance;

(f) requirements for disposal of the VAD substance;

(g) the relevant persons involved in providing or supporting the provision of health or care services for the purposes of conscientious objection provisions;

(h) functions of the Review Board to record and keep information; and/or

(i) any other processes to support the safe and accessible operation of the VAD system.

CEO requirements

8.3 To support the operation of the NT VAD legislation, and pursuant to proposed specific provisions, the CEO may approve additional requirements in relation to:

(a) information that must be provided to a person making a First Request;

(b) prescribed forms that must be submitted to the Review Board;

(c) additional eligibility requirements for Coordinating, Consulting or Administering Practitioners;

(d) mandatory training to be undertaken by participating practitioners;

(e) the type of substance that may be used for the purpose of causing the person's death in accordance with the legislation;

(f) authorised suppliers and disposers of the VAD substance; and

(g) approving a service to be an official VAD care navigator service for the purposes of the NT VAD legislation.

Medication protocols

8.4 All Australian jurisdictions have established a centralised pharmacy service which is the only authorised supplier of VAD medication. To support the safe and consistent delivery of VAD, each jurisdiction has developed a medication protocol to which pharmacists and VAD practitioners must strictly adhere. The standardisation provided by these medication protocols provides additional control and safety over the VAD process.

Professional guidelines and training

8.5 To support healthcare workers and VAD practitioners, comprehensive guidelines have been developed in all Australian jurisdictions. These guidelines typically cover the regulatory framework, the steps in the VAD process, the roles and responsibilities of healthcare workers (with a focus on VAD practitioners), the functions of the Review Board, the role of statewide services, and general clinical guidance.

8.6 The 'Australian model of VAD' includes a requirement that participating practitioners (Coordinating, Consulting and Administering Practitioners) must undertake mandatory training prior to providing VAD; this requirement is also included in these drafting instructions. This training is typically delivered online via a series of eLearning modules that situate VAD within the end-of-life context and educate practitioners about their roles and responsibilities under the legislation, the eligibility criteria and process to access VAD, and the broad regulatory framework. While the training focusses on the legal process, it also provides some clinical guidance and resources. To successfully complete the training and demonstrate competency, practitioners are required to pass an assessment.

8.7 While VAD practitioners play a key role in the provision of VAD, other healthcare workers also play an important role supporting patients accessing VAD, and practitioners providing VAD. Many Australian jurisdictions have developed short online training modules and resources to educate healthcare workers about the VAD process, and their roles and responsibilities.

Implementation of VAD into the health system

8.8 After passing VAD legislation, every Australian jurisdiction had an implementation period (typically 18 months) before the legislation became operational.

8.9 The 2024 Report considered that the NT should also undergo an implementation period (up to 18 months) to allow for the necessary services and structures to be established.

8.10 Drawing on the experience of other Australian jurisdictions, some of the key aims of the implementation period are to:

(a) establish statewide services to support the delivery of VAD, including the navigator and pharmacy services;

(b) develop guidelines and training to educate and support healthcare workers;

(c) design policy to support the safe and compassionate delivery of VAD;

(d) establish the Review Board to provide system governance and oversight;

(e) develop an information management system or other processes to facilitate information sharing requirements under the legislation; and

(f) conduct engagement and consultation with clinical stakeholders and the wider community to ensure that VAD resources and services are fit for purpose and to raise awareness.


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