

Legislative Assembly
of the Northern Territory

Draft Daily Hansard

Thursday 27 August 2026

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Madam Speaker Lambley took the Chair at 10 am.

STATEMENT BY CHIEF MINISTER
Nepalese Flooding

Mrs FINOCCHIARO (Chief Minister): Madam Speaker, this morning I acknowledge the tragedy and devastation we woke up to of what is being called an inland tsunami that has struck Nepal and Tibet.

The situation is still evolving and we do not know the full extent of this tragedy. Reports indicate that 34 Australians are among the missing and the projected death toll reaches 160.

The Red Cross has said entire villages and market areas have been wiped out by the flooding. The scale of the devastation is difficult to comprehend, with communities, homes, roads and critical infrastructure swept away.

The Nepalese community is the fastest growing multicultural community in the Northern Territory and, indeed, Australia. Our Minister for Multicultural Affairs, Jinson Charls, has spoken to Trilochan Sapkota this morning and Namrata Kandel President of the Nepalese Association and President of the Non-Resident Nepalese Association to offer our collective condolences and any support that the Northern Territory Government can provide to our Nepalese community.

Currently the Nepalese cricket team is in Darwin as part of our Top End series T20 cricket tournament. We have spoken to Cricket NT which will be providing an opportunity for a minute's silence before each game that will be played today.

We will continue to support all of the players, team officials and the local community through what is a terrible time of uncertainty and grief for everyone.

The Nepalese Association of the Northern Territory and the Non-Resident Nepalese Association also has an event tomorrow from 8 am to 12 pm at the Jingili Water Park, Jaynai Purima. On behalf of all Territorians we acknowledge the tragic loss of lives and livelihoods resulting from this natural disaster. As the aftermath becomes clearer, stand shoulder to shoulder with our local Nepalese and Tibetan communities and will provide all support necessary.

Madam SPEAKER: I too convey my thoughts and prayers to all those affected by this terrible tragedy to the Nepalese community and Australians affected. It is a terrible thing and we will be watching it closely.

SPEAKER'S STATEMENT
Photographers in Chamber

Madam SPEAKER: Honourable members, I have given permission for photographers to be in the Chamber to take photos on the conclusion of the debate on the Rights of the Terminally Ill Bill.

RIGHTS OF THE TERMINALLY ILL BILL
Serial 70

Continued from 25 August 2026.

Mr DEPUTY SPEAKER: Good morning, everyone. Honourable members.

I am conscious that this is a very important Bill. It is the first Bill that I have done consideration in detail which is subject to a conscience vote. I hope you bear with me. I will treat everyone fairly. I will remind you of a couple of rules.

When you vote, you need to say quite loudly whether you are for or against. I will make a judgement call on who I think are the loudest voices. If you disagree with that, those who disagree with it can seek a division, and you will need support unless you are the Chief Minister or the Leader of the Opposition. Just be aware of that.

We also have a number of competing or complementary amendments to certain clauses. I will be giving the call to the person who first jumps. That is the fairness for everyone.

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I will try and be as fair as I can, but if you disagree, I am sorry. It is just my judgement call and we will move on that way. I remind people this is consideration in detail. It is not the debate. We have already had the debate and a very respectful debate we had.

This is about getting into the detail, the clauses. When we do talk, we will go clause by clause, or if we batch them up to move them on, so be it. I ask that everyone let the speaker or the person questioning speak in silence to the minister and also due respect back to the minister that the minister answer with due respect in science as well.

Thank you again.

Consideration in detail

Clause 1, by leave, agreed to.

Clause 2:

Ms UIBO: My question is to the minister regarding commencement clause. Minister, how long after the Act commences will Territorians be able to access voluntary assisted dying?

Ms BOOTHBY: It will be gazetted within 18 months. There is an 18-month timeframe. That is the minimum timeframe to ensure that it is consistent with implementation timeframes required by other jurisdictions. Depending on readiness, it is possible that provisions may be commenced at different times before the 18 months passes or if ready to go for the whole Act to commence.

Ms UIBO: Is there an implementation plan to coincide with that 18-month timeframe?

Ms BOOTHBY: The implementation will be conducted by NT Health.

Ms UIBO: If so, will making the implementation plan public—will it be provided so that there can be strong community input into that process? I understand that the Department of Health is not your department, but in doing so, obviously there has been collaboration between both the Attorney-General's Department and the Health department. I am hoping that you will be able to answer that question.

Ms BOOTHBY: It is something that NT Health will be rolling out the full implementation. I expect that department will work closely with the minister and the community to ensure that is rolled out.

Ms UIBO: Will you be giving regular updates to the community about the implementation process?

Ms BOOTHBY: NT Health will be responsible for that. Over the next 18 months all that work will be underway.

Ms UIBO: Noting that the Bill is sitting in your name and you are legally responsible as the minister and Attorney-General, will that be an update process that your department, in tangent with the Department of Health, will provide?

Ms BOOTHBY: It is important that we continue the work of the implementation so that it is done within that 18-month timeframe. I can confirm that the NT Health department has that work underway.

Ms UIBO: Is there no commitment on the Attorney-General's department providing regular updates of the process?

Ms BOOTHBY: If this Bill passes today, the work will go to the NT Health department to roll out the implementation.

Ms UIBO: Will you run information sessions, through your department, with the community about voluntary assisted dying and how the scheme will operate across the Northern Territory?

Ms BOOTHBY: Fact sheets will be available online about this Bill. NT Health department will take over the implementation and whatever else needs to come in that 18-month timeframe.

Ms UIBO: Noting that not everyone has access to online resources, Wi-Fi or indeed the internet at all times, will there be community sessions which are run in places that have issues with accessing online resources?

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Ms BOOTHBY: It is important information for people to know about, and that work will be done by the NT Health department.

Ms UIBO: On a similar vein, will there be multiple language resources developed by the Department of Health through the process of VAD and ways to allow people to ask questions, air or raise concerns if they do not speak English as a first language?

Ms BOOTHBY: The NT Health department, through its networks across the Territory, will be rolling out the work needed for that implementation. That will be its responsibility.

Ms UIBO: I note the Minister for Health is sitting next to you and I hope he will take that to his department. It is a critical time for this piece of legislation for a number of Territorians who are either thinking of voting for or against the Bill. For us in parliament today, will you be upfront with Territorians if there are any delays in the implementation process should this Bill pass today?

Ms BOOTHBY: The way in which the Act has been designed is that it will commence on the day of the gazette notice by the Administrator. If a provision of the Act does not commence before the day of this 18 months after the day on which the Administrator's assent to this Act is declared, the provision will commence on that day.

Ms UIBO: If there are delays, will there be some type of notification process from your department to inform the community of such?

Ms BOOTHBY: The NT Health department will be rolling out that implementation and they will be responsible for that communication.

Ms UIBO: In your second reading speech, you said that you will be implementing a decentralised service model rather than a centralised model, as recommended by NT Health. Why have you gone against the advice of the Northern Territory Health department?

Ms BOOTHBY: It does not go to the clause for the commencement and I do not know if there is another space that we could answer that.

Ms UIBO: In the vein of implementation which you have been speaking to as part of commencement, if there is a better place, I am happy to be directed by you as to which clause?

Ms BOOTHBY: The decentralised versus the 'not', this Bill allows for both. It is a policy decision for NT Health for it to be decentralised. That is what I indicated in that speech.

Ms UIBO: Could you explain the advantages and disadvantages of a centralised or decentralised model?

Mr MALEY: A point of order, Madam Speaker! Standing Order 155; irrelevance. The question is not relevant to the clause.

Mr DEPUTY SPEAKER: Minister, do you want to answer the question or not?

Ms BOOTHBY: It is a question for NT Health as part of the implementation. The Bill is the framework to allow for the rights of the terminally ill and access to voluntary assisted dying, and the model in which that is done is delivered by NT Health.

Ms UIBO: Will you ensure consistent clinical standards and safeguards are included, and how will you be monitoring the system given that you are the responsible minister for the Bill; however, another agency is responsible for the implementation of this Bill?

Ms BOOTHBY: It goes to a different clause under the review board and that is how we do that, but that part of it will be with NT Health.

Ms UIBO: How will you address NT Health's concerns about the decentralised model given this Bill is standing in your name?

Mr EDGINGTON: NT Health is working on the model as we speak. There is an 18-month commencement date and that work is currently underway. We will be putting together the best possible model to meet the needs of Territorians.

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Ms UIBO: Does that mean that there is still the ability to have a centralised model?

Mr EDGINGTON: As I said, the work is underway, and it is happening within the department, and we will deliver the best model for Territorians.

Ms UIBO: Will that be policy based or politically based?

Mr EDGINGTON: I have answered that.

Ms UIBO: What budget has been set aside to implement voluntary assisted dying over the next 18 months?

Ms BOOTHBY: That is the work that NT Health are working on now with all the information they have available to them and through the budget process.

Ms UIBO: I am sure you can appreciate the question; I know how budget processes work, minister, and obviously budgets can be altered in between before the budget process, so I am hoping that will be a consideration of your government should the Bill pass today.

What operational budget has been set aside for the VAD scheme—I am assuming it is similar to the last response—but is it a new or an existing or reappropriation to Health's current budget?

Ms BOOTHBY: Yes, apologies for the repetitive theme, but NT Health will be doing that work and they will have to go through the normal processes of a budget and a submission and ensure that all the right mechanisms are in place.

Clause 2 agreed to.

Clauses 3 and 4, by leave, taken together and agreed to.

Clause 5:

Dr RAHMAN: Attorney-General, in respect of clause 5 definition and the definition of residential aged care facility whether any policy choice has guided the inclusion of and reference to the Commonwealth *Aged Care Quality and Safety Commission Act 2018*?

Ms BOOTHBY: That Act sets up aged care; that is why we have used that definition.

Dr RAHMAN: Can I respectfully suggest if that is the case then perhaps that clause needs to be amended as that Act has been repealed and replaced by the *Aged Care Act 2024* last year.

Ms BOOTHBY: Thank you for your feedback.

Dr RAHMAN: I seek clarity as to whether that amendment will be made or whether I need to move an amendment now on the floor to correct that, because I believe it is the incorrect Act.

Ms BOOTHBY: We are looking into it now for clarification so that we can get it right.

There might be a standing order to park that question, Mr Deputy Speaker, and come back to it. I want to get clarification.

Mr DEPUTY SPEAKER: If you wish we can come back to clause 5.

Ms BOOTHBY: It is clause 5, specifically about the 'residential aged care facility' definition. We are checking on the Act. The Member for Fong Lim mentioned that the Act had been repealed. I am not sure whether it has been repealed already or is in the process.

Dr RAHMAN: I am confident that it has been repealed.

Ms BOOTHBY: Already?

Dr RAHMAN: Yes.

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Mr DEPUTY SPEAKER: If you like, we can move to postpone consideration of clause 5.

Dr RAHMAN: I think that definition has a material impact on the subsequent amendments that are being distributed—namely, to clause 14 by the Member for Drysdale and clause 15 by a number of people. Therefore, I think we need to resolve whether we are referring to a repealed Act and a definition that has been superseded or whether we are referring to the *Aged Care Act 2024*, which has a material bearing on the subsequent clauses that we are to consider. If we were to postpone consideration of this clause, I would suggest that we need to resolve it before we arrive at clauses 14, 15, 16 and/or 19.

Ms BOOTHBY: Maybe I can suggest while we look that up to be sure, under Standing Order 156 we can park the question. There might be other questions before questions on the other clauses that I know are important to people in the Chamber. Can we check the will of the room as to whether there are any other questions. I definitely want to come back to it, but I think we could keep moving if it does not affect other questions on this clause.

Dr RAHMAN: I have no objection to that. I have no questions before those clauses are to come up, to be clear, Mr Deputy Speaker.

Mr DEPUTY SPEAKER: We will move to postpone consideration of clause 5.

Dr RAHMAN: Until when are we postponing it? Under Standing Orders 152 and 156, if we postpone a clause it will not be reconsidered until we have gone through all other clauses. As I just indicated, clauses 14, 15, 16 and 19 are materially affected by this definition.

Ms BOOTHBY: If it is helpful, maybe we could postpone it until after clause 13. We will have the answer before then. We are talking to OPC that helped with this drafting.

I move under Standing Order 156 to postpone that question until after clause 13.

Clause 5 postponed until after clause 13.

Clauses 6 to 13, by leave, taken together and agreed to.

Postponed clause 5:

Ms BOOTHBY: The advice I am receiving from the Office of the Parliamentary Counsel is that it had a quick look and the *Aged Care Quality and Safety Commission Act 2018*, under the Commonwealth, has indeed changed to the *Aged Care Act 2024*. They are quickly drafting an amendment for me to table in the Assembly so that we can talk to that amendment. Basically, we have been through checking off the definitions. Of course, we want to get this right, but if there are any other questions while I wait for that to come forward, I am happy to answer those questions.

Dr RAHMAN: Mr Deputy Speaker, if I may, I have a written amendment that I have just handwritten. I can circulate on the same, which I am happy to do if it speeds things up. I am in agreement with the Attorney-General. I am simply saying that I have an amendment here that I can distribute and move if that would suit.

Ms BOOTHBY: Thank you, Member for Fong Lim. I do appreciate that. I do not want to jump into it quickly; I am waiting on the advice still, so we will not be long. It will be quick, but I am happy to take any other questions. Did you have a question, Member for Arnhem?

Ms UIBO: No, I was just going to say I am happy for the Member for Fong Lim to circulate his amendment to assist you, minister.

Ms BOOTHBY: Yes, I was just waiting for some advice on that.

Mr DEPUTY SPEAKER: Minister, I am just confirming, you are getting advice from Parliamentary Counsel?

Ms BOOTHBY: Sorry, Mr Deputy Speaker.

Mr DEPUTY SPEAKER: You are seeking advice from Parliamentary Counsel; is that correct?

Ms BOOTHBY: Yes. We have an amendment to clause 5.

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Mr DEPUTY SPEAKER: Can I suggest, while we are waiting for proper information—is the Assembly agreed that we now move onto maybe clause 20 and come back to the other ones as well?

Ms UIBO: Mr Deputy Speaker, I know the process at the moment is highly unusual to the normal circumstances of our parliamentary procedure. I think if there are any changes or amendments with respect to the Member for Fong Lim's and the minister's looming amendments, I would not be comfortable with skipping clauses and going back. I would prefer to do what we normally do in parliament and go clause by clause. If there is the need to pause this process, I believe it would be in the best interest of the Northern Territory to make sure we get this right—however 'right' may look in people's eyes.

I think it becomes very messy and convoluted if we start skipping ahead and then going back, just in case there are any unintended consequences due to the proposed amendments, the amendments that may pass or not. To ensure that everyone is literally going clause by clause, page by page—I have never seen this process in my 10 years as a member of parliament—we must, as you said at the start, do it with respect and without rushing, but also in the mannerly procedure which I know you are capable of.

Mr DEPUTY SPEAKER: Thank you. Minister?

Ms BOOTHBY: Yes, thank you, Mr Deputy Speaker. Member for Arnhem, I do tend to agree that we should not move around. It is a very long Bill with lots of clauses. Of course, the definitions are intended to be read in conjunction with other statute books, and the wide definitions that are already contained in the *Interpretation Act 1978*, so it is important that we get this right. I respect the questions, and I want to make sure we have the right advice from the Office of the Parliamentary Counsel, which has done a mountain of work to pull this together as it stands and get the balance right in what we have been able to put forward.

I want to ensure that it is the right amendment for Territorians. Obviously, the definition 'residential aged care facility' is an important part of this Bill and clauses relate to that. We do not need to wait too long, but while I am on my feet I think it is important that we ensure those definitions are exactly as intended to be. It is important that we have the right Act referred to under the Commonwealth. Of course, Commonwealth Acts change a lot and sometimes that happens outside of the time we are in parliament.

It has been a huge job for the Office of the Parliamentary Counsel to get through all the different clauses and definitions and to look through all the different reports done. The drafting instructions were well written by the Legal and Constitutional Affairs Committee.

We need to get it right. It talks to other Acts and refers to the *Interpretation Act 1978*. We want to ensure that the right amendments are coming forward.

I am happy to take questions on that, Mr Deputy Speaker.

Mr DEPUTY SPEAKER: Minister, do you have any indication of how long it might be until you get the advice?

Ms BOOTHBY: Very soon; she is in the lift.

Dr RAHMAN: I concur with the Leader of the Opposition and with the Attorney-General that this should be resolved before we move on. If you want to have a substantive debate about it to move proceedings on, I am happy to move and circulate my amendment so that we can discuss the matter. Alternatively, we can simply wait for legal counsel to come through, however long that takes.

Mr DEPUTY SPEAKER: That is exactly what I am trying to find out, thank you, Member for Fong Lim.

Would you like to suspend proceedings?

Ms BOOTHBY: No, I do not think that will be necessary.

Thank you, Member for Fong Lim, for having your amendment. It is probably perfectly fine, but I want to make sure through the right channels at the Office of the Parliamentary Counsel for this particular one. We all agree that it does need to change because that Act of 2018, I think it was, has been repealed.

I will move that amendment. It will be circulated in the coming moments. We need to make sure that it does not refer to the *Aged Care Quality and Safety Commission Act 2018* and that it refers to the current Commonwealth Act. We need to make sure that definition is clear.

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I move to omit from the definition 'residential aged care facility' in clause 5 the words 'Aged Care Quality and Safety Commission Act 2018 (Cth)' and insert 'Aged Care Act 2024 (Cth)'.

Mr DEPUTY SPEAKER: I believe that the amendment has just been circulated now, so the question will be that the amendment be agreed to. I will just give everyone a quick chance to see it.

Ms UIBO: Mr Deputy Speaker, I do not have a copy signed by the minister. I assume it is the one that has just been circulated by the Table Office.

Mr DEPUTY SPEAKER: We have a tabled signed copy.

Ms UIBO: I want to make sure that I am not getting an obsolete version.

Ms BOOTHBY: I will read it out to double-check. This is the Rights of the Terminally Ill Bill 2026, Serial 70, Amendment Schedule No. 70GOV (Ms Boothby). It states:

Clause 5, definition *residential aged care facility*

omit

Aged Care Quality and Safety Commission Act 2018 (Cth)

insert

Aged Care Act 2024 (Cth)

Amendment agreed to.

Clause 5, as amended, agreed to.

Clause 14:

Mr HOWE: I move amendment 1 to clause 14(2). I will read on the public record my reasoning, which I sent out to all my fellow MLAs. This will be on the grounds of clarifying conscientious objection rights in the Bill.

I will say before I move this to conscientious objectors that I would not support the Bill if I did not believe conscientious objection rights were in there. This is to clarify and strengthen, having listened to many of those conscientious objectors.

The amendment strengthens and clarifies the statutory protection afforded to individual conscientious objectors while preserving a direct and practical pathway for a person seeking information or assistance concerning voluntary assisted dying.

Clause 14(2) currently leaves the nature and extent of the information that a conscientious objector must provide entirely to regulation. This creates avoidable uncertainty about the boundary between facilitating access to the VAD system and compelling a person to participate in that system in a manner contrary to their conscience, beliefs, culture or values.

On an issue engaging fundamental questions of conscience, the substantive limit of the obligation should be clearly established in the Act itself. Regulations are more appropriately used for operational matters, such as ensuring that the relevant telephone number and email address remain current. The amendment would not permit a conscientious objector to obstruct or frustrate access to voluntary assisted dying. The objector would still be required to inform the person that the official voluntary assisted dying care navigator service may be able to assist them and to provide direct contact details for that service. The person would therefore retain an immediate and practical pathway to authorised and independent information and assistance.

At the same time, the amendment would ensure that a conscientious objector could not be compelled to distribute, explain or endorse substantive VAD material that may conflict with their sincere held beliefs or values. Their obligation would be confined to the neutral provision of contact information.

This establishes a fair and durable balance. It protects access for people seeking information about voluntary assisted dying, while also ensuring that conscientious objection is treated as a genuine statutory protection rather than uncertain protection whose scope may change through regulation.

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The amendment would also safeguard against future changes in either direction. It would prevent regulations from prescribing material designed to discourage or influence a person seeking access to VAD, while equally preventing regulations from compelling conscientious objectors to provide substantive material that goes beyond the neutral provision of contact details.

Telephone numbers and email addresses would continue to be updated through regulation. Any future proposal to expand or materially alter the substantive obligation imposed on conscious objectives would, however, require an amendment to the Act and consideration of the Legislative Assembly. This would provide greater certainty, transparency and accountability for patients, practitioners and the wider community, irrespective of their position on voluntary assisted dying.

At the core, I spoke at length of my speech of liberty. I believed in voting for VAD, and I hold that same liberty should be true for those who wish not to participate. These words are provided by me and by many health professionals who have agreed to this specific wording who wish to be conscientious objectors in our health system.

Dr RAHMAN: Thank you, Member for Drysdale, for raising this important issue. I respect the intention behind the amendment that has been proposed by the Member for Drysdale, but I will vote against this amendment on a number of grounds, which I will articulate now.

It is quite clear from everything I have been saying publicly in relation to this bill that I am a great advocate for conscientious objection. It is extremely important to me that Territorians have the opportunity to participate in VAD processes or sit out and abstain from VAD processes, as the case may be.

This amendment is well-intentioned but, ironically, will curtail the rights of conscientious objectors, in my opinion. The first thing to note is that it is an important thing in legislation—a standardised boiler-plate thing—to have something mentioned to be later determined as prescribed by regulation.

We know in the Northern Territory that implementation of VAD process in practice will be extremely challenging. There is a compressed time frame, limitations on healthcare resources and on what can be done within existing workforce and budgetary constraints and so forth.

We need to be allowing the Health Department time to figure out how to facilitate communication and information streams when it comes to communicating VAD writ large. That also pertains to conscientious objection.

The first significant point is that it is deleterious and legally negligent to make this amendment and remove any capacity for the Health Department and the state to prescribe regulations so we can clearly govern what is involved in conscientious objection. Why does that matter? Because if you look under the definition of ‘relevant person’ in this Act, there is a range of people listed. We are talking about speech pathologists, social workers, Aboriginal liaison officers, interpreters, healthcare workers and any other person prescribed by regulation. These people all need differing sets of information to know what they can and cannot say and what the parameters of their involvement should be.

The reason we know this is this is a question that has been tested in almost every debate on VAD in every other jurisdiction. In every jurisdiction there has been an important discussion about maintaining safeguards and ensuring that we allow people to meaningful access VAD but, at the same time, we do not curtail access to information, and we do not have a problem with people making decisions under duress.

This clause, as it stands at the moment, Health Practitioner with Conscientious Objections, affords greater protection to people to be able to conscientiously object. The amendment is extremely narrow. Let us speak specifically to the amendment.

The current clause says that a health practitioner or relevant person who, because of a conscientious objection, refuses to do a thing mentioned in subsection (1) for a person requesting information about, or assistance with, voluntary assisted dying, must give the person the information prescribed by regulation.

This is standard, legally sound practice, to be able to say we have a range of stakeholders and classes of people, all of whom should be afforded rights to conscientious objection, but what they need to do will differ. There is a huge difference between a medical practitioner, an Aboriginal liaison officer or a speech pathologist. They can only advise in relation to certain things and there will be certain constraints on them.

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One of the things to remember is that a lot of the questions we will focus on today relate to the unique geography and demography of the Northern Territory. We have a 30% Indigenous population, and we know that there are significant challenges in that regard. We have to be careful about how we communicate medical information. We do not want to—metaphorically speaking—spook the horses in any regard.

That is why it is important for us to work this stuff out later in regulations properly. At the moment, this provision allows for people to conscientiously object on the following grounds:

> *A health practitioner or relevant person who has a conscientious objection to voluntary assisted dying has the right to refuse to do any of the following:*
>
> *(a) provide information to another person about voluntary assisted dying;*
>
> *(b) participate in the request and assessment process;*
>
> *(c) participate in the making of an administration decision;*
>
> *(d) participate in the prescription, giving or administration of an approved substance;*
>
> *(e) be present for the administration or self-administration of an approved substance.*

That is a wide set of parameters that people can conscientiously object about. It is embedded in the legislation, but as will be said a thousand times over today, the devil is in the detail. On this one we cannot prescribe the detail prescriptively.

The government has sensibly drafted a Bill here which already affords ample protections for conscientious objection, and if we take out a legally sound part of it, which is that also anything else prescribed by regulation we will cut ourselves off at the knees. It is an unwise and legally unsound amendment to support, because the amendment at the moment replaces prescribed by regulation with must inform the person that an official voluntary assisted dying care navigator service may be able to assist the person and b) give the person the telephone number and email address prescribed regulation for contacting an official voluntary assisted dying care navigator service.

Those clauses are a cut and paste from other jurisdictions and the presuppose a number of things that do not actually exist for us yet. We do not know what our VAD care navigator service will look like. We really cannot tell. It is implicit that there will be a necessity for one and the chief health officer will have to prescribe somebody to fulfill the obligations of a care navigator service, but at the moment we do not know—will that be a standalone building, will that be a person, will that a hotline, these are questions for implementation and regulation and they cannot be resolved by simply saying provided you provide a phone number and an email address then you are providing accurate information and you can conscientiously object. We simply are not applying a sound legal standard here.

It may be the case that in regulations down the track that it is prescribed in regulation, exactly that. This is the building that we built to be the care navigator service, or this is the person who is the one person on a hotline who is now the care navigator service, and these are the regulations for classes of individuals, whether they are pathologists, social workers, Aboriginal liaison officers, whatever they might be, we can prescribe that at that time, but it is unsound.

This Bill at the moment adopts essentially the vast majority of the Legal and Constitutional Affairs Committee recommendations on best practice for a Bill for the Northern Territory, and that is a wonderful thing. It is worth us remembering and reflecting on the fact that there are relatively few amendments being discussed today in this House. When this Bill happened in Victoria people were arguing about the meaning of night and day. Literally, people argued about everything. We are really talking about refining this Bill today, to make sure that it is the best possible Bill that it can be, and it is important that we provide more clarity around conscientious objection for entities, bodies corporate under section 15, which will be discussed forthcoming, but under section 14 these provisions are absolutely fine in my opinion exactly as they are.

The Attorney-General and the drafters of the Bill are to be commended, in my opinion, for adopting exactly what the standard should be on contentious objection, which is that there are different classes of individuals, you can sit it out for a whole bunch of reasons and all the fine ground detail we will afford the Health department all the time in the world to work out in the right manner, because it may be that things need to be prescribed in language. It may be that things need to be prescribed in video format; it may be part of broader education campaigns. As I have maintained all along there is so much detail in here to wrap your head

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around. We have superseded the days of the original 1995 Rights of the Terminally Ill Act, which essentially just decriminalised assisted suicide and allowed medical practitioners to not be prosecuted for facilitating a voluntary euthanasia process.

Instead, now what we have is a Bill with a huge number of very sensible checks and balances, some items today that we can all look at together to work out if we can work out a better standard on some issues, but by and large we have the option today to consider relatively few important amendments carefully, this is not one of them. I admire the intention behind this and it is reasonable to have raised the issue, but as a matter of legal construction and as a matter of principle this clause is absolutely fine exactly as it is, and it does not require tinkering with and it does not require us doing a DIY renovation, frankly speaking, on what is already a very sound piece of the architecture of the House.

J DAVIS: I understand the intent behind the amendment. I have talked about it with the Member for Drysdale. It is important that we make sure that when we pass this Bill, everyone feels that any concerns they have about whatever might be in this Bill, including conscientious objection, is properly safeguarded. I agree with the Member for Fong Lim that what is currently in this clause provides that, but I understand the intent behind the Member for Drysdale's amendment, but I will vote against it.

Ms BOOTHBY: Thank you, Member for Drysdale, for raising this amendment. I know it is important to the people who have been speaking to you about this issue. I also thank the others who spoke about the amendment.

Regulations give the ability to be flexible and change with changing needs. The amendment would change that approach by replacing the requirement to provide prescribed information with a specific requirement to direct a person to the official voluntary assisted dying care navigator service and provide the prescribed contact details for that service.

Although I understand the intention behind the amendment, the Bill in its current form deliberately provides for the information to be prescribed by regulation. It allows that approach to develop the most appropriate information pathways, service arrangements and referral mechanisms over time, informed by consultation and operational experience. At this stage, those regulations have not been finalised. I would be cautious about locking in any single pathway into that primary legislation for a scheme before it has been established.

Ms UIBO: Does that mean the government minister is not accepting the government member's amendment?

Ms BOOTHBY: I will not be voting for the amendment.

Amendment not agreed to.

Clause 14 agreed to.

Clause 15:

Dr RAHMAN: I wish to speak to the first of three substantial amendments which I think are the critical components of this Bill, which require clarification and correction in order to make this the best possible VAD Bill for Territorians.

We just had a small discussion about the scope of conscientious objection. Clause 15 says that a relevant entity may refuse to provide information about voluntary assisted dying and it essentially does not allow for the free flow of information to terminally ill persons.

The amendment that I have proposed I will speak to in its own right but also with respect to the other two amendments that have been circulated to the Assembly; one by the Leader of the Opposition and another by the Member for Drysdale.

The key point I make is that the section 15 amendment that I am proposing offers broader protections than any of these do. It offers a broader set of ways for any entity, body corporate or residential care home et cetera to opt out of any VAD process that they do not want to be a part of.

The way it does that is in the wording of 15(1)(a), 'a resident, or the resident's agent'. It will then read:

(1) This section applies to a relevant entity if:

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(a) a resident, or the resident's agent, asks the entity for information about voluntary assisted dying or assistance with the exercise of a power under Part 3 (Request and assessment process for access to voluntary assisted dying) or Part 4 (Accessing voluntary assisted dying and death)

That is the whole suite.

Respectfully, the other versions of these amendments that have been circulated again draw from a smattering of ideas and wording utilised in other jurisdictions and create legal loopholes and inconsistencies. They will result in confusion regarding when an entity—a body corporate—can sit out of this process. To some people, it will seem counterintuitive that I am moving this, but as I have said all along, I am not an evangelist for VAD per se; I am passionate about genuine true choice for Territorians to opt in or opt out of VAD processes. That applies to individuals, entities, institutions—as we are talking about here—practitioners and, most importantly, patients.

I am asking the Assembly to consider—this should be one that we can all uniformly get behind—the idea that we should allow entities to have a policy not to provide information about VAD at the facility or not to have to provide assistance with the exercise of any power under Part 3 or Part 4.

The bare minimum obligation is specified in (1A) and (2) of my amendment. The bare minimum obligation is simply that relevant entity must, as soon as reasonably practicable, after the resident or the resident's agent asks for the information or assistance, refer that resident to the official VAD care navigator service.

Mirroring the ask of the Member for Drysdale in the preceding amendment, I am saying that, yes, it is implicit now in the legislation in eight places that a VAD care navigator service will need to be created in some form in order to be able to fulfil the tasks of the VAD Bill.

If we have to create one in some form, then yes, it will be prudent for an entity that opts out to have a minimum requirement to simply, in a practicable and reasonable timeframe, redirect somebody to that. That is all it is.

The second part of that is, again, in keeping with the argument I made earlier, that the relevant entity must, as soon as reasonably practicable, after the resident or the resident's agent ask for the information or assistance, give the resident the information prescribed by regulation. Once again, this is a legally sound method for dealing with this issue.

All we are saying is that an entity, a body corporate as defined in here—a relevant entity means a body corporate that provides a relevant service. It covers the field on the whole breadth. All it means is that any entity is able to sit this process out specifically in relation to the exercise of a power under Part 3 or Part 4, which is the whole thing. All they have to do is refer to the VAD navigator service and do anything else that is later worked out sensibly in regulation. It is a reasonable cover-the-field legal amendment.

It is important to provide genuine conscientious objection capacity for an entity. Why does that matter in the Northern Territory? Because we have lots of places where there is only one entity in a small place. Those entities are often auspiced by religious associations and organisations. Some of them have genuine concerns about whether they will be compelled to participate in the VAD process.

This will ensure that those people are not compelled to participate in the process. It will guide them to be reasonably accommodating. Where did I get those words from—'reasonable accommodation'? From the best practice standard that we have in the literature regarding this. In the debate in the second reading speech, I referred to a paper called *Legislative Options to Address Institutional Objections to Voluntary Assisted Dying in Australia*, published in 2021.

That paper basically sets out that there are three ways of doing this. The middle way is reasonable accommodation. You can say a blanket 'no', you can force institutions to do things that they want to do or you can reasonably accommodate. This amendment relates to making it clear that entities should be allowed to sit out but still have to provide information. It is extremely important to Territorians that we have choice and the freedom to choose to participate in or sit out these processes. I said the other day—half jokingly, but I mean it semi-seriously—that we are the jurisdiction that demands to be able to blow things up on 1 July. We are the jurisdiction that has said clearly, 'The Territory way is the Territory way'. Yesterday the Chief Minister of the Northern Territory in National Cabinet asserted the Territory's right to be able to do things differently when it is best for us.

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In this jurisdiction where were are extremely liberal—some might even say bordering on libertarian in some regards, it is important that we genuinely, even if you are advocates for VAD, respect the fact that there are entities that will want to sit this out. If they want to sit this out, they should be able to do so, but we should do this right legally. The other versions of the amendments that are presented create a series of holes in them. I will not go through them specifically because there is the possibility that those amendments will be raised if this amendment is defeated.

I implore you all, as colleagues, to think carefully about providing conscientious objection provisions that are as broad and reasonably accommodating as possible. I think we should be able to agree on this. It does not make the legislation in any way more progressive; nor does it in any way do anything other than legally tighten up the standard to make sure that there are no holes and no court cases down the line when an organisation wanted to sit out but then felt that it was compelled.

The amendment moved by the Member for Drysdale that has been circulated provides that a relevant entity may still refuse to participate in voluntary assisted dying processes. That version creates so many holes because it is essentially drawn from outdated and outmoded South Australian and Victorian legislative provisions. I do not think it is legally sound to introduce it in any form. I will forensically deconstruct that if necessary.

Regarding the amendment to clause 15 that has been circulated by the Leader of the Opposition, it is important to understand that provision is not unreasonable, but it has a series of holes in it as well. One of the important ones is that it introduces new language in relation to unfair discrimination and to just undertake the request and assessment process.

Basically, other versions of this amendment seek to do exactly what I am seeking to do, but my version of this amendment is the broadest possible construction of this—allow entities to conscientiously object, but simply ask them to be reasonable in providing information to a terminally ill, dying person.

Ms UIBO: I have an amendment for clause 15. It is of a similar nature to the Member for Fong Lim's amendment. I appreciate the description he has provided. For me, the process of consideration in detail is to strengthen the Bill before us, because that is what Territorians want to see, what they deserve and what they should expect.

In terms of my amendment, I would be keen to support the offerings by the Member for Fong Lim in his amendment today in the spirit of the goodwill and good nature which the debate before us has occurred thus far. I am willing to see the Member for Fong Lim's amendment put forward today. A conscience vote by all members is expected, but I believe strengthening the Bill today is the job we all have, regardless of agreeing or disagreeing with certain aspects of it. I look forward to seeing the Member for Fong Lim's amendment to clause 15 being put.

J DAVIS: I speak in support of this amendment. I think, as the Member for Fong Lim explained clearly, this provides additional protections for entities that want to conscientiously object.

I commend the Leader of the Opposition for supporting this. I think we are all here today to ensure we make the best law we can. It is a bipartisan issue. We are here for the people of the Northern Territory. I am grateful to everyone for doing this work and I will support the amendment.

Ms BOOTHBY: Thank you for all of the contributions on this amendment that has been put forward Just to be clear, the amendment moves beyond ensuring access to information and begins to require non-participating entities to facilitate access to specific stages of the voluntary assisted dying process. In effect, it imposes additional responsibilities on entities that have chosen not to be involved in the process. The Bill is designed to ensure that people can access information and support, while also respecting the position of entities that do not participate. I will not be supporting that amendment today.

Mr YOUNG: Respectfully, minister, I support the amendment introduced by Tanzil. There may be only one entity in many communities across the Northern Territory, so people in aged-care facilities, for example, do not have that choice. If they are looking at accessing voluntary assisted dying, they should be given the right to information. I agree with the Member for Fong Lim and the Leader of the Opposition.

Dr RAHMAN: Mr Deputy Speaker, I believe I have the right to reply.

Mr DEPUTY SPEAKER: You do, yes.

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Dr RAHMAN: I will not prosecute the argument again per se, but I am grateful for the support of the Members for Johnston, Daly and Arnhem. I rise ostensibly to plead with and beseech my government colleagues to consider supporting this.

The point that has been made is not technically incorrect, Attorney-General, in that this imposes a new specific duty on an entity, but we have to think about what duty we are imposing on those entities, and the scale of the duty being imposed here is extremely nominal. We are saying to an entity, 'You can sit out any part of this process now'—which is broader than what is provided in any other form—'but if you sit it out, all you have to do is redirect to the navigator service', which this legislation implies will have to exist in eight different locations, and do anything else that is prescribed by regulation.

For example, if we wanted to curtail these provisions in relation to what the onus would be on a body corporate and a relevant entity, we could later—by regulations—say, without being inconsistent with the Act, all that entity needs to do when someone asks for information about VAD and they do not want to participate is hand them a business card. Or it could be that all they need to do is provide them with—as the Member for Drysdale suggested on individual objection—just a phone number and an email address. This could be restricted even further if we feel like we are encroaching on the freedoms of a body corporate to do their business according to their value set. Therefore, I think there is no sound reason not to uniformly support this in this House.

This provides greater protection to conscientious objectors—entities—of which we know there is a great number in the Northern Territory. This provides them with total clarity that they can sit out any part of the process under Part 3 or 4, and just provide the details of the navigator service and do whatever the Health department works out later needs to be done and is in the regulations. For example, it might be that we work out this information needs to be provided to somebody in sign language or a different language or with the use of an interpreter. There are so many possibilities for what needs to be worked out in regulation later.

Other versions of this—for example, the version that was moved by the Member for Arnhem …

Ms UIBO: I have not moved it yet.

Dr RAHMAN: No, the amendment that was …

Ms UIBO: Proposed.

Dr RAHMAN: Thank you. The proposed amendment by the Member for Arnhem, for example, imposes much more specific duties—Attorney-General and colleagues from the government. That would compel a body corporate to do a whole lot of things that my amendment does not. It would have required them to consider unfair discrimination, to undertake a request and assessment process of the facility. That is, in my opinion, encroaching on their turf; I agree.

That is why I have tried to be as broad about this as possible. Those words are so specific there is a reason why we have used the words 'the exercise of a power'. If we had talked about the function, for example, it would be incorrect and mean a different thing again, because that is only applicable in relation to the ACT standard.

I applaud the hard work done throughout the drafting of this, because it is hard to put together all of the ideas that were expressed in the LCAC report and make sure that we do not create new problems and holes for ourselves. It would have been the easiest thing in the world to cut and paste from other jurisdictions on this particular set of ideas and get ourselves in a tangle. What I tried to do, after 10 drafts of this amendment, is avoid that problem.

I am beseeching government colleagues, having heard that there may be support from others in the opposition and crossbench, to sincerely consider taking this amendment on because it is an indication to Territorians of the fact that we are reflective government that listens and knows mistakes can be made and we could improve the legislation. We clearly identified a mistake this morning in definitions referring to a repealed Act, for example. To the credit of the Attorney-General, we have amended that now.

In the same spirit I am saying that at the moment we do not adequately protect entities and body corporates. If we pass this amendment we would provide greater protections to them and allow them to set the process out and simply pass on details to a dying person of where they can get help. That is all this is about, making sure that we can get the right information to someone freely and fairly without any impediment but, equally, that we do not impose any unnecessary obligation on an entity.

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I will leave my remarks at that.

Mr MACKAY: Regarding the clause that is being amended here—a question for the Attorney-General. The way clause 15 is worded, is there any requirement in this Bill that a relevant entity—be it an aged carer or body corporate—facilitate or have to facilitate any other step of the VAD process other than to just provide what information is prescribed by regulation?

Ms BOOTHBY: As it is currently drafted, there is no positive obligation.

Mrs ZIO: I want to put on the record that I am supportive of the amendments that the Member for Fong Lim has proposed in regard to this clause. I also appeal to my fellow colleagues in the Chamber to support these amendments.

Dr RAHMAN: It is important, in the question that was raised by the Member for Goyder and the answer that was supplied by the Attorney-General, that we introduced this important idea of a positive obligation. That is exactly what we are balancing in this Bill across the board: positive obligations, liberty, freedom and choice.

Again, the standard must not be that we say doing anything is bad. We are the state, and the state has made a Bill on behalf of the government. It is a government Bill, not a private member's Bill. The state has made a series of choices inside this Bill already about what it thinks is the right balance of things. It is not that we are not imposing positive obligations in a range of areas in this Bill. There are a number of positive obligations that are being set on individuals. Basically, it would not be unreasonable in the slightest to impose on a body corporate or an entity this tiny positive obligation to simply be reasonably accommodating and in a timely practical fashion, just provide a redirect to a dying person to the VAD navigator service, and to do that in whatever manner and form is prescribed by regulation that we work out is most reasonable in the future.

Throughout this debate we will have many discussions about positive obligations, what we are requiring individuals, doctors and patients to do. We are doing a balancing act all through today about the rights of individuals, where the state should step in and where it should butt out. We have made so many choices in here already to try to get the balance right and, as best as possible, learn from past reports and adopt recommendations that we spent time thinking about.

There are obviously a couple of key places where that deviates, which we will be discussing coming down the track, but this one is a no-brainer. This one is allowing entities to conscientiously object in exactly the spirit of the amendments that were proposed by others, and I am asking for the very barest minimum of obligation on positive duty on an institution. Just pass on the details of the navigator service and do it in whatever form is reasonable and reasonably accommodating.

Mr SMELT: Mr Deputy Speaker, I support the reflections made by the Leader of the Opposition and the amendments that she has proposed. I also acknowledge the Member for Fong Lim and the exhaustive work that he has done on this clause, and I put on the record that I will also be supporting this amendment.

Mr DEPUTY SPEAKER: Honourable members, I ask your permission to appoint the Member for Goyder and the Member for Arafura as the tellers.

The Assembly divided:

Ayes 8	Noes
Mr Brown	Ms Boothby
J Davis	Mr Burgoyne
Mr O'Gallagher	Ms Cahill
Dr Rahman	Mrs Carlson
Mr Smelt	Mr Charls
Ms Uibo	Mr Edgington
Mr Young	Mrs Finocchiaro
Mrs Zio	Mrs Hersey
	Mr Howe
	Mr Kerle
	Mr Mackay
	Mr Patel

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Mr Yan

Amendment not agreed to.

Clause 15:

Ms UIBO: I move amendment 1 in Amendment Schedule 70OPP to replace clause 15. The reasons of the rationale extend beyond the recently defeated amendment by the Member for Fong Lim. In the best interest of this Bill , and Territorians, our job today is to improve this Bill so that it is fit for purpose and we have the best possible laws for Territorians going forward.

The reasons for my amendment today is to ensure residents of institutions are not denied information about voluntary assisted dying on request, allowing them to make an informed choice about end-of-life options. Consistent with the LCAC report, which found institutional objections to VAD can be more of a barrier to access than an individual practitioner's objection, a person can more easily consult with another practitioner. However, it is harder to overcome an objection from a hospital aged-care facility.

Similar to what the Member for Daly outlined, in electorates like my own and the more remote and regional away from towns and cities, unfortunately, the less choice some Territorians have in accessing other providers. There may only be one provider in their town, community or homeland, therefore limiting access to information based on these restrictions that are currently afoot in the Bill.

The belief to improve this Bill, so it is the best possible, the federal *Aged Care Act 2024* says that residential facilities must not hinder permanent residents from requesting being accessed or access in VAD. Our Northern Territory voluntary assisted dying law should also reflect this sentiment in line with the Commonwealth Act. I would like to, through this course and from the many people who have lobbied me and other members in this Chamber, ensure that the NT VAD laws would relate to not just hospitals in this instance, for the reasons I have outlined.

The LCAC report also found that this was a major omission that hospital patients could be blocked from access for aged-care residents legally cannot be. It also argued, through its extensive work and consultation—I remind the Assembly this was a government dominated committee—that the rights and responsibilities of institutions should be set out in legislation so that they are clear. Although the amendment that I am proposing is similar in principle to the Member for Fong Lim's, mine also includes provisions for making a request of undertaking an assessment and not just an information exercise for voluntary assisted dying.

The processes in the Northern Territory, particularly with law making, should always reflect the context and challenges, but also the opportunities for Territorians to have the most information and opportunity possible. The way the law is currently drafted in this Bill does not cover or address the issues I have raised and the reasons for the amendment, particularly for people in my electorate of Arnhem and people in areas where there is a smaller population and therefore limited access to alternative sources which can provide information and have consultation. I believe that my amendment goes further than the Member for Fong Lim's amendment in that respect. I circulated this on Tuesday to allow all members more opportunity to dissect the information. Unfortunately, I did not have the opportunity to discuss it directly with any members other than my Labor colleagues, who have asked questions about all the amendments and not just my own.

In good faith, I would like to see every member in this parliament doing their due diligence in ensuring that we do not see a restriction on information and access and opportunity for Territorians to be able to be guided by this law should it pass today in the House.

We are talking about the history of voluntary assisted dying in the Northern Territory. We have the benefit of being the last jurisdiction in the country to go through this process, so we could learn from what has and has not worked in other jurisdictions. Some jurisdictions are several years ahead of us. As we know, the Australian Capital Territory and the Northern Territory have not had the opportunity to go through this process until after 2022, when the Restoration of Territory Rights Bill was passed and restored in the Commonwealth Parliament.

We are at a milestone process for the Northern Territory's history, three decades after it was a landmark piece of legislation in not just the Northern Territory but the world. In the spirit of good faith, I hope every member of parliament has read my amendment and they understand my amendment, particularly the one that is afoot today, clause 15, and that they vote with the best interest for this provision which I am proposing.

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I want to see the extension of what the Member for Fong Lim proposed in my amendment to be recognised with the push that institutions must be able to support residents' access to information and go further for consultation. The important thing to note today—we have said it many times; it is not just a political line—is that when we talk about voluntary assisted dying we remember it is just that: voluntary. It is not mandated, but I do believe that people across the Northern Territory, if this is their consideration, are provided with the most respectful, mature, open and transparent opportunity to have information and consultation and not be limited because of where they live. In the Northern Territory, we all understand that access to information and services is limited the further away you get from our cities and towns.

On behalf of the best interests for my electorate, I do not want the people of Arnhem to be at a deficit in accessing information or support if this VAD law is passed today. I will ensure that, to the best of my ability, that I am able to represent the people that I serve. I understand that many people across the Northern Territory outside my electorate would expect the same of all of us here today.

In the interests of the Bill being fit for purpose, I do not believe we have to be on the back foot here, because we could be on the front foot by ensuring that regardless of your personal opinions on voluntary assisted dying, they will not limit another person accessing information or consultation around VAD in the Northern Territory. It is our duty in the Territory. It may not be for some, but other people should not be limited in that process. That is the reason I am proposing the amendment today.

Mr MACKAY: I am seeking clarification. I thank the Member for Arnhem and the Opposition Leader for providing this amendment. Subclause (1)(b) of your amendment as well as (2) would provide a positive obligation that all entities would have to allow the undertaking of requests and assessment at their facilities. Is that correct?

Ms UIBO: Yes.

Mr MACKAY: And

> *(2) that relevant entities 'must not unfairly discriminate against a resident facility operated by the entity because the resident requests information about voluntary assisted dying or decides to undertake, or asks questions about undertaking, the request and assessment process.*

That would mean that entities would not be able to say—like discriminate against—'This is a no-VAD facility'. Is that the intent? I am just trying to get my head around it too.

Ms UIBO: Yes, that is correct. Similarly, what the Member for Daly spoke about in his support of the previous amendment that was proposed, some of our Territory residents only have access to one facility, perhaps in a remote community context which may be run by a religious institute and therefore may already be, by default, conscientious objectors, which means that any resident in that facility would automatically be dismissed in terms of being able to ask for information as a resident in that institution.

To avoid the discrimination against that resident, the reason why I am proposing the amendment today is to ensure that regardless of who runs that facility or that institute, that they still have the equal rights to access information.

The reason why I have also gone with 1(b) in the clause is I would not want to see a case where a resident in a facility requests information or support to access information for voluntary assisted dying and their position as a resident in that institute then becomes at risk. That is the reason.

I want to ensure that there is no negative discrimination against that resident. They may only have that one institute or facility to access that support, particularly when we talk about aged care facilities, because of perhaps an overlying element of a religious institute being the one who commissions that facility.

For me, it is a real concern because of the context of my electorate, but also other places that I have visited across the Northern Territory that do not have any other options. I would not want to see—because of the drafting of the clause 15 and the current Bill—that religious institute or facility able to object and then Selena Uibo—the requesting resident requesting information of VAD—then loses her residency at that facility because of the conscientious objection of that institute. I hope that is clear.

Mr YOUNG: Similar to what I spoke to the Member for Fong Lim and again with the Leader of the Opposition's request to amend this part of the Bill, I agree with this strongly. We sat on the committee that went out and

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spoke about voluntary assisted dying. I give the example in Tenant Creek where there is only one aged care facility down there.

Currently, if you are a resident at that aged care facility and you are asking for information about voluntary assisted dying, and if the policy of that facility is to deny the opportunity to speak about VAD, then that resident is denied that right to have the conversation to start the choice of voluntary assisted dying. We need to bring it back to the principle of the Bill, which is around choice and giving people that choice to look at access regarding voluntary assisted dying. I will be supporting this amendment.

And Philip Speakers, Member Fong Lim. Thank you very much, Mr. Deputy Speaker.

Dr RAHMAN: This is not my preferred iteration of clause 15, as I have already pointed out but it is still an improvement on where clause 15 is at now, which for the reasons that have been outlined, means that terminally ill people in entities will get no information.

That is not what we are about and not what this bill should be about. We have to be providing Territorians with real choice and freedom of access to information. It is difficult to see how we cannot support it in that regard.

This set of amendments does more than what I wanted to do. All I wanted to do was ensure that entities could set it out reasonably but at least provide information.

Now my amendment has failed, and I accept that. This amendment goes further, but it still does the right thing by terminally ill people, people who are dying, people who are suffering, people who are elderly, people in places like Tenon Creek where, frankly speaking, you will just not get the information. You will not get access to bad services, and to suggest anything other than that is just untrue, so we need to make some change on this if we want to genuinely say that this Bill is about affording rights to the terminally ill. I mean, that is the honest truth.

The Bill is not asking for terribly much, if I am honest. It is more than what I wanted, as a as a legal nerd. I wanted it to be perfectly perfect and water tight so that an entity did not have to do anything except just provide a bit of information. This requires them to do more, but what it asks them to do, personally speaking, I don't think is unreasonable either.

As a matter of philosophy and consistent with the discussion we had and trying to get support across this House for us to work together, I thought we could all agree on my version of 15, and that might be indicative of the fact that we are willing to listen and make sure Territorians at least have choice and access to information, but the clauses it stands now denies them that.

We collected mountains of evidence and testimony throughout the bush, which the Members for Daly, Wanguri, Blain and the former Member for Nightcliff heard. We heard it over and over again; people just want access to the information and choice. It is the same thing over and over again: ‘I don’t mind if other people have it, even if I don’t want it; I just don’t want to be told what to do or not to do.’

That is the same for individuals and institutions. The trouble with this version of 15—you have to understand that because of the Territory’s unique circumstances geographically and demographically, which is not the same as everywhere else, a lot of other VAD Bills and things that are proposed and cut and pasted assume that there are multiple providers, and that if something cannot be done in one place, you can take them somewhere else.

We just do not have that option in the Territory. We have one hospital, and we have a private hospital that cannot provide a lot of services now that we know about. We have single aged-care clinic facilities pretty much everywhere outside of Darwin. Even in Darwin, we basically have one private provider, Pearl, and three public ones. So these are meaningful changes and if we are just obstinate about it and just dig our heels in the sand, I do not think you can really call this the Rights of the Terminally Ill Bill anymore.

We could call it a voluntary assisted dying act that has narrow access to it, a framework legislation. That is fair enough. The original architect of the Rights of the Terminally Ill Bill has obviously made lots of public statements about this. I thought really hard at the top of today about opposing clause 1 on the basis that I thought maybe we should come back and postpone it and consider it after all of these clauses, including this one, were considered.

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But ultimately, I thought, no. I don't really want to play any dumb procedural games. I just want us to try to agree on some of the basic good bits, like giving people freedom of choice and respecting people's option to sit in or sit out without asking them to do too much.

To the substance of this, 15(1)(a), as proposed by the Member for Arnhem—just ask for the entity within a reasonable period to provide information prescribed by regulation, first of all. Again, I think that is a legally sound thing to do. There are too many bits of this legislation where we are talking about curtailing things that we need time to figure out. We will need time to figure out in practice how to implement VAD so we respect the rights and liberties of people and we do not end up getting the balance wrong.

On 15(1)(b), I agree that it goes further than what mine did. This now says that a relevant entity, an operating facility, must allow somebody in the facility to do the request and assessment processes at that facility. I was willing to be legally dogmatic and say, 'No, you can't do anything. Let the institution opt out completely.' But again, what is the ask here? We are essentially saying to an institution, 'You have to let a sick patient in your clinic talk to somebody'. That is it. That is what the request and assessment process is—a series of doctors, healthcare workers, practitioners, as defined throughout the Bill, having the opportunity to have a conversation with you. The elderly person who is terminally ill is in a facility—whether it is in Darwin, Tennant Creek or Alice Springs—at the moment can be frustrated into being able to participate in VAD at all. It is like full stop. That does not seem compassionate, fair or reasonable to me.

In this House I mostly ponce around talking about data, statistics, evidence and best practice, but this has to be a matter of compassion on this. Compassionately speaking, all I am asking for is for us to support this amendment that will now allow people and yes, institutions, to opt out, but it will also allow sick, dying people access to a doctor to come and talk to them. That is it.

The request and assessment processes for the Australian VAD model are insanely cumbersome, in my opinion, but that is the standard that has been settled across the country. That is the standard that we have adopted within this Bill. You will have to let multiple people, first assessments, second assessments, et cetera—all of that stuff will have to happen somewhere.

If you have a patient who is crook and cannot be moved from their facility and is in one-clinic town, what will you do? You h ave somebody who is elderly, dying and in Tennant Creek and has nowhere to go. Now, you are denying them the right to even have a doctor visit them and talk to them about VAD? This is not even including if they raised it and said, 'I want to talk about this'. If the facility says no, that is it. You will have to figure out how to get that person somewhere else. How on earth will you do that?

We have a range of practical considerations that have not been properly addressed in the Bill and that is why we need implementation time to figure out some things in regulations. I would be opposed to this Bill if the Member for Arnhem had also said, under clause 15(1)(b), 'request an assessment and administration process', for example. If we had asked for any of the exercise of function under Part 4 of the Bill, that is fair enough. That is legitimately a hard line in the sand. You have to be able to say, 'No, not in my house. You can do it somewhere else, but not in my house'. I am asking for Territorians to be allowed to have conversations with doctors about their healthcare.

There is an interweaving of these amendments—15, 16 and 19—and some of the other ones that have been fairly raised as well about having truth in the Bill, which we will come to later today. I cannot, in good conscience, say that this is a Bill that is about giving Territorians freedom or choice over VAD if we cannot do something on 15 because, as the Member for Daly pointed out—I remember that conversation in Tennant Creek, even though I was half dead in the hospital for most of those consultations, which is another story. I remember the ones in Alice Springs better.

I am asking the guys from Alice Springs to think about this. I remember being there—you can look at the testimony in the Old Timers Home where nurses who had come from Victoria and were working in our system were so frustrated because they had been blocked at every stage from being able to provide information to elderly dying people.

On this one, please reconsider as a matter of compassion if nothing else, because we have to allow Territorians to have genuine choice if they are terminally ill. This cannot be a Bill for the rights of the terminally ill if we restrict conversations in these premises.

Mrs ZIO: I only have a few words. People already know how I feel about this aspect of the Bill. I talked about it in the Member for Fong Lim's amendment.

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A couple of years ago, my son's girlfriend committed suicide. One of the first things that happened was I went and approached his psychologist and had a chat to him about it. He repeatedly reiterated to me, 'Talking about suicide with your son will not promote him committing suicide. Talking about the topic will not promote somebody to do it.'

Providing someone with information about voluntary assisted dying will not make them want to do it for no reason. Please, I appeal to the members of this parliament again—talking about a topic does not make somebody go through with it; it provides information to people. Stopping people from getting important information about their condition, what options they have does nothing other than allow them to make an informed decision.

J DAVIS: Mr Deputy Speaker, thank you, Member for Fannie Bay, for saying that so articulately. I also support this motion for similar reasons to supporting the motion from the Member for Fong Lim.

I remind people that in the Explanatory Statement one of the key principles of this Bill is a quality of access to the end-of-life process regardless of where a person lives in the Territory, that is precisely what this motion goes to. We have heard from people whose electorates have only one facility where people may be, and as the Bill stands those people will not have a quality of access to the end-of-life process. If this amendment, as the amendment from the Member for Fong Lim, directly supports the intent of the Bill, so I support it.

I also note, as the Member for Fong Lim said, that 15 be allowing a resident to undertake the request and assessment process does not compel the entity to do anything. The entity does not have to take any positive action in terms of enabling voluntary assisted dying. It is purely allowing people to get access to information when they may not be able to otherwise.

I thank the Leader of the Opposition for bringing this amendment, and like the Member for Fannie Bay I urge people across this parliament to make sure that the Bill we pass today actually honours what the intent of the Bill is in the Explanatory Statement. Thank you.

Mr MACKAY: Mr Deputy Speaker, I thank those who have already spoken on this amendment. To clarify because there has been some moving of the discussion a bit. The original clause 15—I am seeking clarification—means that any entity that is covered under the body corporate, be it aged care, nursing care, whatever it might be, has to provide information prescribed by regulation, so that no entity would be able to say I cannot provide that information, I am not going to, they have to provide that information.

Ms BOOTHBY: Yes, that is correct. I completely respect all the contributions so far about the clause about the amendment that the Member for Arnhem has put forward, but going back to the clause which we put forward in the original Bill, it is all about the fact that if a person initiates that discussion they will, even if they are a conscientious objector, have to provide that information, but that is it. They do not have to do anything else. The more we change the clause to allow—or ask them in a positive duty that they have to do more and more erodes the whole point of the conscientious objection philosophy of this Bill to make sure that people who do not want to participate, either in a health clinic, in a remote community, a doctor or nurse that works in a remote community, they have to still provide that information—that is in the legislation, but they do not have to do anything else. We do not want to open the door to have participation in those facilities, for those entities that are conscientiously objecting for a very good reason.

Ms UIBO: I thank all speakers thus far on this amendment. Thank you, Member for Johnston, for going back to clause 15 (1)(b) regarding the wording which has been very carefully—allow a resident to undertake the request and assessment process at the facility. There is nothing in the current drafting with respect to clause 15 that says that process is allowed to be undertaken at the facility. Again, to the point of being heavily prescribed in my amendment is to ensure that there is no negative discrimination against someone to be able to access. If people are wondering how it will work in a practical sense, the Member for Daly and I had some discussions about someone who may be bedridden who is in one of those facilities. They would not be able to necessarily physically leave that facility to then go and undertake an assessment consultation and a process that may or may not lead to them accessing voluntary assisted dying.

I echo the words of the Member for Fong Lim in terms of allowing health professionals, a care plan, and even family members to have those conversations with a person who may or may not be able to leave the facility. I think crystallising that process in this amendment creates the safeguards to ensure that any resident—any Territorian who is in one of those facilities—is not left without access. As the Member for Fannie Bay said articulately—thank you for sharing that very personal story—it is so we do not create a block to information.

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As the Member for Johnston said, in going to the principle of the Bill—allowing Territorians the rights that every other Australian has to access information and consultation should they want to go down the pathway of voluntary assisted dying. Someone initiates that process. They may choose not to pursue voluntary assisted dying. That is up to the individual. The key word in this is the work that has been done over many years, months and particularly the last few weeks. Indeed in the last few days and hours, there has been a lot of collegial conversation by all members of parliament, and I thank them for that. It has been respectful in that sense.

The overall intention of the Bill is to ensure that every Territorian has access to VAD choice. The practicality is there are people who do not have any other option or are limited to one type of facility in their caring stage. With respect, I would expect that any facility or institution that is caring for a terminally ill Territorian would take it as their duty to ensure that Territorian, in their final weeks, days, months or years, is supported to access information, support, care and medical services regardless of where they are in the Northern Territory and who is caring for or supporting them.

I honestly and wholeheartedly put forward this amendment to ensure that all Territorians can access information and consultation. If there are other physical or philosophical barriers to that access, this Bill becomes disingenuous, because there will be people in our Northern Territory healthcare and aged-care systems who will not have the genuine support to go through a process that any other Territorian in other circumstances will have the equal opportunity to do.

I highly recommend this amendment for those reasons. It means a lot to me not only in representing my electorate but also for the many people who have advocated to ensure that we have a blanket system and a process that is engaging, supportive, genuine and accessible to all Territorians. From the debates that were had on Tuesday, I believe that a majority of members of parliament believe this to be true. Therefore, I highly commend this amendment to ensure that we are not just saying those words, but protecting them in law as well.

Mr SMELT: I will reflect briefly on where we are at in terms of the overall Bill. It is pretty clear that the Bill will pass today. To my knowledge, no member of parliament has come out and said they are voting against the VAD Bill. What we are doing now is looking at the details of the Bill—the devil is in the detail, as the Member for Fong Lim said—but we want to look at how can we strengthen and improve it. How can the 24 of us contribute to making this a better Bill?

The important thing about the amendment moved by the Leader of the Opposition, in this case, is that it provides a positive duty. It flips it. Information must be provided. Not only that; it goes further and puts into law that the assessment must be allowed to occur. As other members have spoken to today, that is critically important if someone is unable to leave the facility that they are in.

Ultimately, the legislation should not discriminate about where a person is living or where they are being supported. It should not impact their ability to access information or to have assessments undertaken. I do not think we can leave it all to the regulations. The regulations would have to do a lot of heavy lifting if it is all on the regulations. I support this being enacted in the law, not just in the regulations.

On that basis, we had the Member for Fong Lim's amendment that was not supported. I encourage people to support the Leader of the Opposition in this amendment.

Mr EDGINGTON: I want to speak briefly in regard to the proposed amendment. The current section, as it stands, requires the relevant entity to give the resident information prescribed by regulation. What the Leader of the Opposition is asking this Assembly to consider is enshrining in this legislation what a facility can and cannot do.

I know from working out bush and in Tennant Creek that this section allows those relevant entities to develop their own policies. Those policies in small communities, including Tenant Creek, may well be generated by the people who live there and, secondly, be culturally appropriate and consider the best wishes of Aboriginal people living in those areas.

What this proposal does is tell those entities what they can and cannot do. This, as it stands at the moment, is flexible enough for those providers in remote areas to decide, in consultation with the Aboriginal people living in those areas, to put policy in place which meets the cultural beliefs and practises of the people living in those areas.

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As it stands at the moment, this is about providing information. It provides a positive duty. Just like when somebody approaches a conscientious objector, it puts a positive requirement on the entity to give that person the information prescribed by regulation.

I can see where the Member for Arnhem is coming from, but I cannot agree to prescribe in legislation how the relevant entity will operate in a remote area when it can put in place its own policies which will be driven by the community members living in that community.

Ms UIBO: I appreciate the Member for Barkly's views on the amendment. I wholeheartedly disagree with what he just said. In clause 15, titled 'Relevant entity may refuse to provide information about voluntary assisted dying' if, as clause 15(1)(b) says:

the entity has a policy not to provide information about voluntary assisted dying at the facility.

If this is the intention of the clause, we might as well just call this the Bill that allows some Territorians access to information about the rights of voluntary assisted dying versus those who do not have a choice because the facility that they accessed and being supported with care from. If a policy-by-policy decision is made for institutes and facilities, as is written in the Bill currently, then it will automatically dismiss access to information for any residents in a facility or residence that has this policy applied—for whatever the reason the facility applies a particular policy—to not allow access to voluntary assisted dying.

We are automatically disadvantaging Territorians in accessing this. It goes against the genuine principle of what we are all debating respectfully today. One thing I refute—I know we are just about to go for a lunch break—is the ability for Aboriginal Territorians, based on religion or culture, to still access voluntary assisted dying information. I think that is a cop-out; I think it is crap, and I do not think it is allowed the consistency of equality for all Territorians regardless of colour, age, sexuality or religion to be able to access information when it comes to voluntary assisted dying.

Mr EDGINGTON: Clause 15, subsection (2), 'the relevant entity must give the resident the information prescribed by regulation'. There is no doubts about what the Bill proposes.

Debate suspended.

The Assembly suspended.

VISITORS

Madam SPEAKER: Welcome to all of you in the gallery this afternoon. It is good to see so many people.

Members: Hear, hear!

Darwin High School

Madam SPEAKER: Honourable members, I advise of the presence in the gallery of Legal Studies students from Darwin High School accompanied by their teachers. On behalf of honourable members, I extend a warm welcome.

Members: Hear, hear!

APPOINTMENT TO COMMITTEES
Member for Araluen

Madam SPEAKER: Honourable members, I report that pursuant to Standing Order 181, the Member for Araluen has been appointed to the following committees on 27 August 2026: the Legal and Constitutional Affairs Committee, the Privileges Committee and the Standing Orders Committee on ICAC.

NOTICES

Ms UIBO (Opposition Leader): Madam Speaker, I give notice that on the next General Business day I shall present a motion calling the Assembly to:

1. recognise the importance of ensuring the Northern Territory is prepared and adequately resourced for emergencies during the current El Nino weather event and heightened risk of extreme conditions

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2. ensure appropriate preparedness and response measures are in place, particularly given the upcoming and likely severity of this year's bushfire season, exacerbated by the proliferation of buffel and gamba grass

3. ensure appropriate support for pastoralists and landholders in preparing for upcoming severe weather events, as well as alert, evacuation and emergency shelter arrangements are in place for remote and regional communities.

QUESTION TIME

East Arnhem Region – Commitment by Government

Ms UIBO to CHIEF MINISTER

After two years in government today, you have shown resident in Nhulunbuy and the broader East Arnhem region you do not care about them. Both you and your Treasurer have cut infrastructure projects in the region and provided no detailed funding commitment for the future transition of the township of Nhulunbuy. When you had the opportunity to represent the region well, you and your party have failed to do so. How can the people of the East Arnhem region now trust anything you have to say when you and your CLP team have clearly decided that Mulka does not matter?

ANSWER

Madam Speaker, I am overjoyed that Labor has decided to ask me a question. Normally, I miss out, so it is fantastic to have the opportunity to talk about somewhere that this government has been focusing on for two years, unlike the previous Labor government which lapsed Nhulunbuy and the people of East Arnhem to rot on the other side of the Territory, out of sight, out of mind, without a transition plan.

I will give you a little history lesson, Opposition Leader. When I came to government one of the first things I did was seek a briefing on what the status of Nhulunbuy was and what was happening there. I was obviously concerned that the clock was ticking on Rio pulling out of that town. I needed to know what Labor had done over the last eight years and where we were at. I wanted to make sure we drove it home for the people in that region.

I should not be surprised, but do you know what I found when I was briefed? Nothing. The Gove Futures Reference Group had been meeting, going around and around in circles, achieving zero progress because it was not being led by either the federal Labor government or the Territory Labor government, which I found abhorrent.

We are talking about thousands of people in a critical region to the Territory who are facing the prospect of half their town disappearing and of the mine where royalties to all of the traditional owner groups there are so important evaporating before their eyes.

We quickly put our cards on the table straightaway and got to work with Rurratjingu Corporation and Gumatj. It is only the CLP government that can claim to have reached an in-principle agreement on land tenure with Rurratjingu Corporation. It is only the CLP government, led by me, Opposition Leader, who is fighting your colleagues in Canberra to recognise that Nhulunbuy can store 250 million litres of fuel in the tanks that Rio will tear down if Albanese—your mate the Prime Minister—does not do a deal with the Gumatj Corporation and the Rurratjingu Corporation.

I was in Garma talking about Djawa Yunupingu, Wanyubi Marika and I having written to the Prime Minister. We continue to push this point because it represents a generational opportunity to support that critical transition in Nhulunbuy.

The hypocrites opposite will be hypocrites; they do not know anything better. She might be a little jealous because we have done more in two years than they did in eight when it comes to the Nhulunbuy transition.

We will continue to work cooperatively in good faith with my assistant minister for Nhulunbuy transition to make sure that the people of Nhulunbuy are never forgotten and that we work with traditional owners to get the very best outcome.

DRAFT

National Gun Buyback Scheme and Data Centres

Mr O'GALLAGHER to CHIEF MINISTER

I am overjoyed. Yesterday you attended National Cabinet, where you secured important outcomes for Territorians on firearms and a future regulation of data centres. Can you update the House on the agreement reached with the Prime Minister and other state and territory leaders, including the decision that law abiding Territory firearm owners will not be forced into a national buyback scheme? I have already been contacted by local residents, which includes Mr Victor (inaudible) in Karama, praising your efforts for protecting their rights.

Can you explain how the Territory's unique energy circumstances have been recognised in the national approach to data centres? Please outline how these outcomes demonstrate the CLP government's approach to standing up for Territorians and protecting affordability, reliability and the Territory lifestyle.

ANSWER

Madam Speaker, I thank the Member for Karama because he is out there fighting for the people in his electorate. Our sports shooters and firearms clubs are out there on the edge of his electorate doing an amazing job.

Madam Speaker, I came back from National Cabinet in the wee hours of this morning with two wins for Territorians—one, to confirm for law-abiding firearm owners that there would not be a forced a quantity limit put on their firearm ownerships. It is unlimited. Also, that we would not be forced or railroaded by the federal government into participating in the national buyback scheme. These are two very important moves.

The National Cabinet agreed on the three principles that I said we should start to work on from the very start. It makes absolute sense. We focus on criminal intelligence sharing from the federal government to the states and territories. It makes sense that we legislate with 3D printers, which we have already done as a CLP government. It also makes sense to have citizenship rules that reflect gun ownership with Australian citizenship, with exemptions for people who are workers.

This is great news for law-abiding gun owners in the Territory. I was the first state leader to come out and put my flag in the sand and say that Territorians would not have quantity limits and would not be part of the buyback. That is exactly what I have delivered and come back from Canberra with.

On data centres, the federation has agreed there needs to be a nationally consistent approach when it comes to some really key areas that Australians expect there to be regarding data centres. That includes data sovereignty, data security, water usage and location. That is the work that the federation is doing now—the Territory, all my state and territory counterparts and the Prime Minister, as the Commonwealth moves to legislate towards the end of this year. We are on that journey together and it makes sense.

The win for Territorians is that we had it recognised very clearly in this national way of moving forward that the Territory's energy system is different and requires a different response. The deal I secured reflects that we have Beetaloo gas coming on in five days' time, that we have state-owned generation, transmission and distribution, that we are not part of the national electricity market, that we have a very strong uptake of renewables across the Territory which will continue into the future and that the CLP's energy policy is this—Member for Karama and your constituents will want to hear it—that affordable and reliable energy comes above all else. That is what we did, delivering to Territorians. It is excellent news for the Territory on the economic and lifestyle fronts.

Whenever I attend National Cabinet, I can assure Territorians I have a 'Territory first' approach and come home with the goods, which is what we did last night.

Road Infrastructure

Mr PAECH to MINISTER for INFRASTRUCTURE

I have just returned to Darwin from Kalkarindji for the Freedom Day Festival. It was a wonderful festival. However, what was not wonderful was the condition of the Buntine Highway since the last Wet Season. Will your government commit to fixing the Buntine before the next Wet Season?

ANSWER

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Thank you, Madam Speaker and I thank the Member for Gwoja for the question. We have a large rural and remote road network that is used not only to connect communities but to drive business, our economy and push the Territory forward.

You only have to look at what has happened this year the weather events and the effect it has had on our road network. Just this week in Central Australia we had three roads cut due to weather events; that is in August which is unprecedented. What has also been unprecedented is the weather events across the entire year, particularly in the first quarter of the year. We have seen huge impacts on our road networks across the Top End, across the Barkly region and, of course, across Central Australia.

Rebuilding our roads begins with a safe, reliable and resilient road network. We have current investment and upgrades into the Buntine Highway, the Carpentaria Highway, the Sandover Highway and Western Creek Road. Those roads programs are valued at around $648m comprising $518.5m from the Commonwealth and $129m from the Northern Territory government for the contributions to those roads.

We are investing in our remote roads but as I said our road network is large.

Mr PAECH: A point of order, Madam Speaker! Standing Order 110; thank you for the numbers, but I wanted to know about the action. Minister, can you confirm if the Gurindji people can expect to see work started on the Buntine before the Wet this year?

Madam SPEAKER: Minister, you have the call. I think you have answered it.

Mr YAN: I am working towards answering it, Madam Speaker. But that point of order was different to the question that I was initially asked. I will do my best to answer the Member for Gwoja.

As I was saying, our roadwork network is vast—two years we have been in government and we are still fixing the problems left behind by the previous government and these have been exacerbated by the weather events. To give some context to the Member for Gwoja for what is taking place on those roads, the Buntine Highway, we have work under way, a tender value award of $318,000 and that is for the design from Chainage 26.5 and we also have work on design from Chainage, 256 to 300 at a value of $703,000.

We have work on construction commencing quarter four in 2026, so there will be work happening out on the Buntine Highway, but it is a large road and we cannot get to it all at once and there are a lot of other roads across the Territory. Every person here would want all their roads done but as we get the funding and get to those roads, we will be doing the repair work and the upgrade work that all Territorians expect us to do. It will take time but we will get there.

Progress Update

Mr HOWE to CHIEF MINISTER

This week marks two years since the Finocchiaro CLP government was elected with a clear mandate to reduce crime, rebuild the economy and restore the unique Territory lifestyle. I have no doubt it is what the people of Drysdale want: less crime and more money in their back pocket, and I want them wealthier.

Can you update the House on the progress the CLP government has made over the past two years and can you outline the reforms and investment the CLP government has delivered to ensure the Territory continues to grow with greater certainty and security into the future?

ANSWER

Madam Speaker, the Member for Drysdale I know that crime and the economy are two massive issues you are fiercely passionate about because, of course, if we get that right people can have the very best life for themselves and their family. Having represented the good people of Drysdale before I know all too well that is what they want to see from you and from our government and it is exactly what we are delivering.

Two years on, being in government we can be very proud of what we have achieved. There is a lot more to do, Member for Drysdale. You know that I know that, and we understand that as a team. The mess left behind by Labor was profound, but we are getting on with the job and cleaning it up. The size of our broom is big, and it is full of energy.

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In coming to government, we have graduated 259 more police onto the streets in the last two years. We have introduced police public safety officers—there is another graduation next month—who are out there in public housing, dealing with antisocial behaviour, public facing police, to allow our constables to be doing the crime investigation and the detailed work.

We have delivered our police the strongest pay deal in 20 years to make sure that they feel valued again after having the previous Labor government turn its back on them. We are putting downward pressure on crime with 10,000 fewer offences under our CLP government than under the previous Labor government.

Our economy is turning around. We have the highest-ever number of people employed in the Northern Territory. Business confidence is returning and job vacancies are up by 31%, meaning that more people are staying but more are needed. Population growth is running the fastest in the nation at 1.6%; construction work is up by 68.6%; and residential building approvals are up by 45.8%. We are outperforming national growth.

We have paid out 592 home build and FreshStart grants, putting people into home ownership.
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We have four nation-building projects happening in the Territory. These projects are not on a fictitious Labor list that those opposite used to wave around as though it would magically happen by osmosis; they are real. In five days Beetaloo Sub-basin gas will be powering Drysdale homes, businesses and industry. There is the Northern Marine Complex, a 5,500-tonne ship lift, supported by 246 hectares of water frontage, to have a maritime industry in the Territory. Arafura Nolans Rare Earths is a $1.6bn critical minerals and rare-earth mine, 135 kilometres from Alice Springs. The Territory Energy Link is a 670-kilometre corridor that will be the super highway for the Territory for water, pipelines, gas, energy, data—you name it.

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Renters' Rights

Mr SMELT to ATTORNEY-GENERAL

The Northern Territory has some of the weakest protections for renters in Australia. The Northern Territory is also the only jurisdiction in the country where landlords can still increase rents every six months. At the same time, Territory renters are dealing with rising rents and increasing cost-of-living pressures. Why does your new four-year Housing Strategy fail to strengthen or protect renters' rights?

ANSWER

Madam Speaker, the Member for Nightcliff has been in the Territory for only a short time and in our Chamber for a shorter time, so maybe he should speak to his colleagues about this. The Leader of the Opposition could explain how this works.

It can be tough in the Territory. Sometimes it is hard to get into the housing market, especially after nearly a decade of Labor destroying the Territory's economy.

Housing affordability can be tricky, which is why we are doing the work needed.

The minister for Housing has released his Housing Strategy. We are focused on unlocking the land available, which is what the Minister for Lands, Planning and Environment is working on in suburbs, like Zuccoli in my electorate. This will give more land releases so that more people can build homes. The Treasurer has being working to get the home build scheme up and running. There is $50,000 available for first homebuyers who build a new home and $30,000 for people who have already owned a home and are building another one. That might be good for people who wish to downsize or rightsize. It also means that people from interstate or overseas who are looking to move to the Territory, can build, live and put down roots here. That is how we make the housing market become a better place for Territorians. We want more private home ownership, which means we need more houses. Why not get Territorians, and those who have moved to the Territory, to build those houses? That is how we change the Territory.

The construction that comes from those builds through the home build scheme—we heard that the percentages are phenomenal. Our CLP government has turned that around in two years. Under the Labor government—Territorians will never forget this—things were in the toilet; they were going down fast.

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Mr SMELT: A point of order, Madam Speaker! Standing Order 110; the Attorney-General has not gone anywhere near renters' rights in this response. It is clear that the Housing Strategy fails to provide any protection or strengthen rights for renters.

Madam SPEAKER: Attorney-General, you have the call; get to the point.

Ms BOOTHBY: I do not think he likes the answer or the fact that after only two years in government we are getting a lot of runs on the board and things are turning around. Under his team—which he keeps trying to distance himself and pretend like he is a new part of a party which is just not true. He is part of the Labor Party through and through. Or maybe he is a Greens member because he certainly has a lot of Greens credentials. I am not sure, but maybe we should remind the new Member for Nightcliff about the fact that Darwin is now the most affordable capital city in Australia. That is unbelievable that we can have that kind of thing be attractive.

If you are a new business looking from down south where it is freezing cold, up the Territory …

Mr SMELT: A point of order, Madam Speaker! Standing Order 110; we still have not touched on the subject of renter's rights. At all.

Madam SPEAKER: Minister, you do have some time to get to the point of the question.

Ms BOOTHBY: If you were living down south in the freezing cold, if you are looking to the Territory we have amazing weather, we have the best payroll tax regime in the country, so you could start a business here. You could come here and get a whole heap of thousand dollars, $30,000, $50,000 to build a new house. That allows …

Madam SPEAKER: Your time has expired, minister.

Reef Fish Stocks

Mrs CARLSON to MINISTER for AGRICULTURE and FISHERIES

Territorians voted for the government that would reduce crime, rebuild our economy and restore our Territory lifestyle. This week we celebrated a fantastic two years since the Finocchiaro CLP government has come to office, and there has already been much work with our recreational fishing industry. With the previous eight years of the opposition—can you update the House on the recent steps that you can take to help sustain our reef fish stocks?

ANSWER

Madam Speaker, fishing is important for the Territory lifestyle. There are lots of people who go fishing in the Northern Territory. It is part of our lifestyle. One in three Territorians over the age of 18 go fishing. Fishing is a great Territory lifestyle. It can be done alone or with family. I go with my family and to spend time with my children in the boat, relaxing, talking about life. More importantly it is about having some time for yourself. It all about Territory lifestyle.

Today a $1.6m contract has been released to put more artificial reefs into our harbour to attract the reef fish so that we can go fishing. In the eight years of Labor government it did nothing. It was simply too hard for Labor to make any decisions about rec fishing. It put it in the bin. Labor did not want to do it because it was all too hard. We will concentrate on wrecking our crime and destroy our economy. We are turning that around. We are making sure that if you go fishing in the harbour you can have a good time and you might be able to catch a goldie or a Jew fish.

This project develops how a Territory-based company can deliver specialist marine products into our harbour. This will benefit our harbour and a Territory company. In fact, there will be 50 large reefs and 20 smaller reefs. I have seen the videos of how this works. The fish, especially the goldies, use the reefs as well as the little fish which stick to the reef, so people can fish there. The previous Labor government in the last 20 years did nothing, and fish stocks went down, but this is a step forward to make sure that we can have more fishing to restore our Territory lifestyle.

Fishing is a great part of our lifestyle, and the reefs will help us. There will also be a new pontoon at Corroboree which will make fishing safer. Places like Corroboree where you put your boat in, then the car needs to put away, then you have to go back and navigate a rocky ridge, or mud or crocodiles, this pontoon

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will make fishing in the Northern Territory safer and our lifestyle will be improved because fishing is a part of life and we love it.

H5N1 Bird Flu

Mr BROWN to MINISTER for AGRICULTURE and FISHERIES

Many Aboriginal Territorians, including those in my electorate hunt wild birds such as magpie geese and other species for food. With the threat of H5N1 bird flu, can you confirm what information is being provided to the people living in remote communities about how to safely handle, prepare and eat these birds, and can you clarify when and how that information will be rolled out, and also in language?

ANSWER

Madam Speaker, this bird flu is going to be an issue here. We are the last country in the world to have gathered this bird flu on shores in southern states. It is safe to say it will get to the Northern Territory at some stage.

This is a federal-led process. The federal government, Labor's mates in Canberra, is taking the lead in this. We are working hard with them because we know this will impact right across Australia—not only birds, but mammals as well. I think there are some cases of seals getting involved, and a fox yesterday, so this will impact people in Northern Territory.

If you do have animals in the Territory, you need to register a property identification number. Go on the website and get that done now so you can get up-to-date and relevant information from the department if bird flu is coming. It will come to one area to start with, and we need to find it, avoid it and report it. There is also a website; off the top of my head, it is just birdflu.com.au. I can get back to you with the with the correct one, but if you just type in bird flu, you will get that website. It has all the information that you need if sick or dying birds or mammals in your area.

I stress, if you see that, please report it because it will be a big thing when it gets here, and it will get here. We do not know when, but it is coming, so we need to be ready for it. People across the Territory, whether in Alice Springs, Arnhem Land or Port Keats, must be very careful and report it because it will impact us; there is no question about that. it will impact your chickens at home—I have chickens at home. We need to be ready for it. It will get here and it will be a concern.

Back to this being a federal-led thing, go and talk to Albo and ask the feds to put enough money into it. There is another federal website, agriculture.gov.au, but bird flu is another one you can check out as well. There are two websites that you can visit, do some research and get ready for it. If you are a leader, a community council or you have a big organisation, do the work now and get ready for it so the people who you work with and manage are ready for it, too, because it will hit the Northern Territory and have a devastating effect.

H5N1 Bird Flu – Supplementary Question

Mr BROWN to MINISTER for AGRICULTURE and FISHERIES referred to MINISTER for LANDS, PLANNING and ENVIRONMENT

Will the government commit to providing communications through the Aboriginal Interpreter Service?

ANSWER

Madam Speaker, I will pass to the Minister for Lands, Planning and Environment. He has some more information about that.

Mr BURGOYNE: Madam Speaker, I thank the minister for Agriculture because his department has been leading the work in regard to H5N1 bird flu. The Department of Lands, Planning and Environment has also been working hand in hand with the department of Agriculture to ensure that we are working with the relevant stakeholders.

Surveillance for bird flu within the Territory is being undertaken through my agency, and we are working with the Northern Australia Quarantine Strategy department, which is with the federal government. We have also been working with Aboriginal ranger groups, which goes to the heart of your question, Member for Arafura.

DRAFT

We have been working with Aboriginal ranger groups to get the message out on the ground. Be on the lookout for this. If you see those birds …

Mr YOUNG: A point of order, Madam Speaker! Standing Order 110; relevance. The question was directly about the communications strategy. The government has its own agency with the Aboriginal Interpreter Service; will it be using that service to get the communications out?

Madam SPEAKER: Yes, it was quite specific, minister, if you could answer the question.

Mr BURGOYNE: We are working with Aboriginal people on the ground, getting out there and spreading the word that we are dealing with this issue.

Mr YOUNG: A point of order, Madam Speaker! It was directly to the Aboriginal Interpreter Service, which is a government department.

Madam SPEAKER: No, there is no point of order. Take a seat, Member for Daly. The minister has answered the question.

Road Infrastructure

Mr MACKAY to MINISTER for LOGISTICS and INFRASTRUCTURE

In my rural electorate, constituents are always talking to me about roads. Roads are the lifeblood of the Territory and how we get around, and it is important that those roads are safe. Everyone across the Territory wants better roads. We know that roads are the heart of our economy and our lifestyle. I was very pleased to see the $1.8m tender awarded for the Bees Creek intersection at Freds Pass Reserve has now been awarded and looking forward to work starting in the coming weeks. Can you update the Assembly on the significant program of roadworks now progressing far and wide across the Northern Territory?

ANSWER

Madam Speaker, it is great to see that intersection at Bees Creek getting done, because it has been an issue in the past. The Member for Goyder has been a big advocate to make sure that that project gets underway to provide safe roads for everybody.

Under the CLP, road improvements are rolling out across the Territory. We are not just making announcements like the previous government; we are getting out on the ground and doing the work. From the Top End to Central Australia and from our major highways to the roads connecting our regional and bush areas, this work is underway.

Budget 2026 invests more than $2bn in our transport infrastructure. Almost half of the Territory's infrastructure program is going into roads. I will give a little bit of an idea on where some of that money is going. We just completed the Plenty Highway part of the Outback Way, with 27 kilometres of upgrades. This was delivered by a local Northern Territory business, creating employment for 69 employees and 14 apprentices. There is work going on for the Commonwealth on Kakadu roads, and this is a significant package of improvements across Kakadu to provide safe, reliable access to some of the Northern Territory's most iconic locations. There is a $100m road investment from the Commonwealth being delivered by DLI and Territory businesses, and this includes the Kubara Road, Maguk Road, Jim Jim Falls Road and the Gunlom and Gimbat Roads.

Just this week we released a tender for Tiwi Island roads, Member for Arafura. A tender was released yesterday for 15 kilometres to upgrade and seal Pirlangimpi Road on the Tiwis. Santa Teresa Road, as I said yesterday, the tender is under assessment. This is for 22.5 kilometres of ceiling and upgrades, and we are hoping to see that tender awarded within the next week or two. Central Arnhem Road is under construction, being awarded $21m for the next stage of the road-sealing program in July. This project has been on the books since 2019, yet the former Labor government delivered just 25 kilometres.

The CLP is getting on with delivering 32.4 kilometres in construction and another 27 kilometres currently in design. There is work happening on the Sandover, Roystonea Ave in Darwin, the Stuart Highway and Bees Creek intersection, which is the Member for Goyder raised, and the Tanami Road. There is 50 kilometres going on out there. The current construction totals another $75m in investment in this economically important corridor. We have $30.5m in flood recovery repairs, which is under delivery now to continue to repair the enormous damage caused by this year's floods.

DRAFT

This is what delivery looks like. This is what the CLP is doing. Unfortunately, the former government could not match the targets that we are now producing.

Police Watch Houses

J DAVIS to CHIEF MINISTER

Chief Minister, on 20 August the Northern Territory Police Force stated publicly that its records of how long young people spend in watch houses should not be relied upon and that those records may not accurately reflect the actual length of time a young person remained in a watch house. This data goes directly to the reliability of decisions made about young children in custody.

Has the commissioner advised the minister that watch house detention duration cannot be reliably reported and, if so, on what date?

ANSWER

Madam Speaker, what is the Member for Johnston referring to? Do you have a document or something you are getting this information from?

Madam SPEAKER: Through the Chair, the member is free to answer that, if you want.

J DAVIS: It was in the public space. I am happy to provide you a copy of that.

Mrs FINOCCHIARO: The public space is a big place. I cannot possibly give an answer without the context. Suffice to say, our police are doing an incredible job every day. I can tell you, Member for Johnston, who emptied watch houses, and it was not your Labor mates. They used watch houses as a prison. Every watch house across the Territory was full to the brim, being used for extraordinarily long amounts of time as prisons. The previous Labor government was happy to maintain that position because it did not have the guts to build a new prison.

Upon coming to government we not only strengthened our laws and backed our police but also brought online new prison infrastructure. More rehabilitation has happened under a CLP government than under Labor, despite the pressure, and we have emptied the watch houses. Now watch houses are used for shorter periods between someone being put before the courts and—once someone has been bailed they are obviously free to go …

J DAVIS: A point of order, Madam Speaker! Standing Order 110; relevance. The direct question was: has the minister been advised that this data cannot be relied on? I am happy to provide the reference of where the data came from, if the Chief Minister would like it.

Madam SPEAKER: I think we are misusing Question Time. You did not provide that information in your question, so it is up to the Chief Minister how she answers it. There is no point of order.

Mrs FINOCCHIARO: How a watch house works is police arrest someone, bring them to the watch house and they are then either bailed and released with conditions—whatever the situation might be—or remanded in custody. They move through a process and within a few days they are transferred to a Corrections facility.

Now we are building a youth remand centre in Alice Springs at the Paperbark facility. We have already opened the bail and supported bail accommodation side from which we are running youth boot camps as well. The other side, which should open in a few months' time, is a youth remand centre. It will be a purpose-built facility for young people who have to be remanded in Alice Springs.

We have seen crime numbers reduce significantly Territory-wide. Is there more work to do? Absolutely. However, we do not back away from that. Just last sittings, we passed more powers …

J DAVIS: A point of order, Madam Speaker! Standing Order 110; relevance. The question was: has the commissioner advised the minister that watch house detention duration cannot be reliably reported and, if so, on what date?

Madam SPEAKER: The Chief Minister started her response by saying without knowing the context or seeing a document, she cannot answer the question. How she uses her opportunity to answer is up to her.

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Mrs FINOCCHIARO: Under Labor, the Territory was in the grips of a deep, dark crime crisis. We were elected on a platform to reduce crime, rebuild the economy and restore our unique Territory lifestyle. Therefore, we make no apologies for making law and order our number one priority, with the best pay deal for police, our new PPSOs and more police on the ground and more to come. I am going to a graduation tomorrow afternoon.

We are proud of that work, particularly the work that Corrections has done. There are now 100 prisoners in post-release work placement support through Corrections. That never happened before. We will support them for 12 months to get back on track.

Major Events

Dr RAHMAN to MINISTER for MAJOR EVENTS

I was one of the 18,352 Territorians at Marrara Stadium from 13 to 16 August, and what an incredible atmosphere there for those four days. For true fans of test cricket, whether you might be partial to Bangladesh or Australia, it was an absolutely magnificent few days of cricket. What struck me even more was seeing our hotels full, our restaurants buzzing and so many visitors from across the country. There were in fact 6,000 people from interstate, and 2,500 came from Victoria, most of whom I saw at the Darwin Festival at the same time, I might add.

After years of treating major events as one-off announcements, can you update Territorians on how this government is using events like the test cricket to restore our lifestyle, grow our visitor economy and showcase the Territory to Australia and the world?

ANSWER

Madam Speaker, This is probably the best question I have had all year. I saw the Member for Fong Lim there. He was at the cricket for four days; it could have been five, but we did not go that far. The Member for Fong Lim loves it. I met the Member for Fong Lim's brother as well. He was not watching the cricket; he was working. He was in charge of the event, which was amazing. It was great to meet him. Member for Fong Lim, you look very much alike.

The cricket was fantastic. We ended up with four days of cricket. People kept saying, 'There will be only two days because Australia is gonna smash them', but that was not the case at all. The only hitch we had was the Member for Fong Lim's stepdad walked out onto the field, got himself in front of the screen and they had to halt play and the whole international television coverage so that people could get him off the field. It was cute. I am sure you were supportive of your stepdad to help him off the field.

The international test cricket at TIO Stadium in Darwin was fantastic. Our government worked hard to make sure that, with NT Cricket and Gavin Dovey—a big shoutout to you—we had been advocating for a long time to have this. We are proud, as the CLP Finocchiaro government, to bring back international test cricket to the Territory after 22 long years.

Labor did not care about international cricket or T20 which we had last year which was a massive success. We had two games that time and it filled TIO Stadium twice over. There were so many people from not only interstate but internationally as well.

With the four days of test cricket there were over 80,000 people loving it. Fantastic. I said to the Member for Fong Lim, 'Tell me the truth. Do you go for Australia or Bangladesh?' I loved his answer. He said, 'I go for cricket'. I get it the way it is; you just love it. I know what you mean by that, because I go for the fact that we can get so many people into a ground and so many visitors to the Territory. That is what I go for as well. I get that answer; it is not always about the team, even though it was cool to have Australia here.

Thank you to Jake Weatherall who spent so much time in the Territory leading up to that game. I am sorry the way it turned out for him, but he was a trooper. He was out there at all the tourism attractions. He was doing lots of filming. Those have been telecast across the world. The commentator could not stop talking about how amazing the pitch was at Marrara's TIO Stadium; the sunsets were; the food was and the Territory was. You cannot pay for that kind of marketing across the world. We know millions of people tuned into that cricket. I am proud that we, as a government, were able to bring that back after 22 years. There will be so much more to come because we will not wait another 22.

DRAFT

Pine Creek Region – Police Coverage

Mr YOUNG to CHIEF MINISTER

Earlier this year residents from Pine Creek handed me a petition with 161 signatures from people from Pine Creek Kybrook region regarding your decision to cut full-time police officers in Pine Creek. Many health workers from Pine Creek spoke to be regarding their concerns about being able to respond to emergencies such as car accidents. They cannot respond until police have been onsite. The closest police are either in Katherine or Adelaide River, so it means it is delaying that response by up to an hour.

Can you give the status of the Pine Creek Police Station and explain why you have not actively engaged to ensure we have a full-time police presence in Pine Creek so health workers can respond to emergencies in a timely manner?

ANSWER

Madam Speaker, policing happens across the Territory. There is 1.5 million square kilometres in which our police are every day protecting Territorians. These types of operational decisions have to be made from time to time by our police.

We know that at Pine Creek the facilities were so old, run down and neglected by the previous Labor government that police could not be there anymore.

The model police prefer to move to is to run Pine Creek operations out of Katherine. Katherine is about to receive, I think, 10 more police tomorrow, which the Member for Katherine be happy to hear. They have more than their full complement of GDs, might I add. They will get 10 more on top of what is already higher than their set number of GDs. That will support Pine Creek and all of those regions in the policing responses.

I know that people in Pine Creek have been concerned about this move. Obviously, it is disappointing to them. However, they should rest assured, knowing that they are not forgotten; that this is just a change to the model of operation; police will still come and be in Pine Creek. Once we bolster those additional numbers they will feel that presence even more.

This replicates across the Northern Territory. We have remote police stations that have been completely neglected. It has been the cause of the ire of the Northern Territory Police Association for many years. I spent eight years as shadow minister for Police, so I know how neglected this has been. That is why we are proud, as a government, to have budgeted more than $140 million just for infrastructure in remote areas. This is remote infrastructure for our police, with police housing and police stations. We have the Maningrida Police Station happening right now, which also includes police housing.

This investment has to happen. We need our police supported in the regions. We know the regional footprint is important. And in fact, as you get further and further remote in the Territory, police become so much more than just police. They are running a number of services. We saw that play out significantly during the floods and cyclones we had during the last Wet Season where our police were the trusted people on the ground delivering the services that Territorians need no matter where they live.

This continues to be a focus for us. This was an operational policing decision and I am sure with the additional police going into Katherine that people in Pine Creek will fill that presence more and can rest assured that they have not been forgotten. The policing services will still be delivered in Pine Creek.

Seniors Month

Mr PATEL to MINISTER for SENIORS

Restoring the Territory lifestyle means making sure Territorians of all ages have opportunities to participate, stay connected and enjoy their communities. Indeed, we have just seen during this important senior month of August, how important this is.

Can you please provide the House with the report on Seniors Month 2026, the government's support for our wonderful senior Territorians and how the CLP Finocchiaro government is supporting our unique Territory lifestyle.

ANSWER

DRAFT

Madam Speaker, one thing that all members of this Chamber would agree, would be how our seniors are incredible. They are really looked after by Territorians. And then when it comes to Seniors Month we had an exceptional month of different activities funded by the Northern Territory Government. There were around 250 events funded by the Northern Territory Government

Out of that there were many that were exceptional that I was able to attend with many of my colleagues and I know that everyone had a good time with the seniors.

One of the other major events here, along with the Chief Minister, I was able to host more than 500 seniors at the seniors' morning tea. It was an excellent morning tea. There was great feedback from all the seniors about the opportunity for people to come together and celebrate seniors month.

Member for Katherine, I have seen you have been having a good time with the seniors from your electorate and from wider Darwin as well. And I have seen, in the last month, the Members for Katherine and Karama, dancing with seniors at multiple events as well. That is what it is all about. We are working with the seniors and supporting them. That is the message we want from the Northern Territory Government, because when it comes to restoring the Territory lifestyle, it is a very important part of our three key pillars. There are more than 25,000 seniors currently living in the Northern Territory and that number is expected to raise up to 35,000 by 2035–36.

We are looking at real practical cost-of-living relief for the seniors as well. As at 30 June 26, there are 22,818 individual members across the Northern Territory Seniors Recognition Scheme and also the Northern Territory Concession Scheme as well.

As of 30 June 2026, a total expenditure of $9.753 million in the NT Seniors Recognition Scheme alone has been paid out as well. That means money going back to everyday Territorians, to Territory businesses and to the Territory economy.

Another important thing happening in Parliament House is the Portrait of a Senior Territorian, which is open until 30 September, and the People's Choice Award is still open. I recommend everyone to go through the different portraits of wonderful seniors and cast your vote on which is your preferred one.

The Department of the Tactile Arts will be able to select the most popular by 30 September.

I thank the Ministerial Advisory Council for the Senior Territorians and also Sue Shearer from COTA NT for the wonderful work you are doing as well.

Ms UIBO to MINISTER for ABORIGINAL AFFAIRS

With your lacklustre attempt to release and produce an Aboriginal affairs framework which has resulted with no key actions or key performance indicators attached, will you commit to meet and speak with the communities, regions and homelands that have developed local decision-making agreements (LDMs) and work with them to either extend or support new LDMs in your tenure as the Minister for Aboriginal Affairs? If not, will you commit to meeting with each of the LDM signatories and explain to those regions, communities and homelands why you and your CLP government do not support local decision-making, their vision and their years of hard work towards self-determination?

ANSWER

Madam Speaker, upon coming into government, we made a commitment regarding empowering the bush. We made that commitment because of the ongoing failures of the Labor government over many years. People out bush have been asking for a long time to be empowered to look after their own communities. That is the focus of this government and why we now have an Aboriginal affairs framework. We said with our commitments that we would honour the 20 local decision-making agreements which were put together under the former Labor government.

Labor has a poor track record in working with Aboriginal communities, and this goes back as far as 1988. That was when the then Labor Prime Minister was at Barunga promising that there would be a treaty for Aboriginal Australians. That was 38 years ago. This is part of the ongoing failures of Labor over the years.

Ms Uibo: You just scrapped all the work on treaty yourself as the Minister for Aboriginal Affairs.

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Madam SPEAKER: Opposition Leader, cease your interjections.

Mr EDGINGTON: It is not just the treaty. The Northern Territory Government made an attempt to bring in treaties as well. It promised a treaty. Michael Gunner promised a treaty back in 2018. He signed an agreement to do so with the four land councils on the 30th anniversary of Bob Hawke's promise in 1988. Thirty years later, Labor signed another agreement to bring in a treaty. Labor held an inquiry and got a report back from the Treaty Commissioner in December 2022. The NT Government released its response regarding that treaty report, and what did it do? There was no press conference.

Ms UIBO: A point of order, Madam Speaker! Standing Order 110; the question specifically asked whether the minister will meet with each of the local decision-making agreements signatories and explain to them, yes or no, will they be extended past the expiry dates and, if not, why not?

Madam SPEAKER: That was the question.

Mr EDGINGTON: After receiving that treaty report, what did the now Leader of the Opposition do? She put it on the shelf, closed the office and stopped any further progress towards the treaty. This is a part of the record of the former Labor government. It scrapped law and justice committees in 2005 and scrapped all the community government councils in 2008.

Our policy is to empower the bush. We have committed to implementing the 20 local decision-making agreements.

Ms UIBO: A point of order, Madam Speaker!

Madam SPEAKER: If you are going to ask the same question again, I would advise you not to bother. Is there a different point of order?

Ms UIBO: Standing Order 110; the question is specifically about local decision-making agreements.

Madam SPEAKER: Minister, you have the call.

Mr EDGINGTON: That is what I was talking about.

Ms Uibo: You were talking about 2005 and 2008. Just answer the question.

Mr EDGINGTON: I am giving the history of your poor record in regard to working with Aboriginal communities in the Northern Territory because all you have done is disempower Aboriginal communities since 1988. You have done nothing to restore local decision-making.

We are getting on with the job of empowering the bush and implementing 20 local decision-making agreements.

Veterans Games

Mrs ZIO to MINISTER for VETERANS

Madam Speaker, I have loved hearing the answers in Question Time today. We have talked a lot about all the amazing events that have been happening over the last few months in the Dry Season in Darwin. Lifestyle is one of our important strong commitments and restoring our Territory lifestyle, especially in communities such as Fannie Bay. As a keen sportsperson and volunteer, I am proud to see the Finocchiaro CLP government has again supported the Veteran Games in Darwin in September. Could you update the Assembly on how the return of the Veteran Games will strengthen our lifestyle for our veterans and the wider Northern Territory community?

ANSWER

Madam Speaker, I acknowledge two veterans in the Chamber, Members for Drysdale and Arafura, for your service to the nation. I can confirm that Darwin will host the Veteran Games for the second consecutive year after the success of last year. It will be on 18 September at the Robertson Barracks. Restoring lifestyle means making sure every Territorian has the opportunity to participate, connect and belong and that includes our veterans.

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The Northern Territory has the second highest veteran community per capital with approximately 20,000 in total with 5,000 serving members, 5,000 ex-serving members and approximately 10,000 family members. The games are a great example of lifestyle we want to restore, community connection, mateship, participation, healthy competition and a strong sense of purpose and belonging.

This event grew significantly last year and every defence unit at Robertson Barracks will represent this year. This is bringing our veterans together, both current and ex-serving defence personnel and it is an opportunity for them to work as part of a team and competitors to take on physical and mental challenges, including obstacle courses, mission scenarios and tug-of-war, testing teamwork resilience and problem solving.

The Territory government has supported this event through Operation Thrive, and we are proud to support again this year, the winning Darwin team will receive $20,000 grant to represent Territory at the 2026 national finals on the Sunshine Coast in October. We want veterans to have every opportunity to stay connected, active and engage in the Northern Territory. That is what restoring lifestyle is about, stronger communities, connections and more opportunities for Territorians to participate. The Finocchiaro government is proud to stand behind our veterans.

Next week is Legacy Week, and there is an opportunity for everyone to proudly contribute and support the appeal which will help the veterans' families. Everyone needs to go to the website, legacy.com.au/donate and you will be able to either buy a badge or a bear and that money goes back to the veterans' families. As the Member for Sanderson, I am also proud to support this, as I have done for the last two years, and in my electorate office at the Northlakes Shopping Centre, there will be badges and bears on sale as well.

Public Housing

Mr KERLE to MINISTER for HOUSING, LOCAL GOVERNMENT and COMMUNITY DEVELOPMENT

Reducing crime and restoring the Territory lifestyle are key priorities for the Finocchiaro CLP government. Better housing has an important part to play in community safety and improving the lifestyle for all Territorians. Under Labor, tenants got away with antisocial behaviour to neighbourhoods and damaging homes with few consequences. Better housing creates a stronger foundation for better health, education, employment and family outcomes. The CLP government is delivering practical action to improve housing and give more Territorians the security and stability they need to build a better future. Can you update Territorians on the work underway to deliver more safe, secure and suitable homes across the Territory?

ANSWER

Madam Speaker, the Member for Blain is passionate about getting housing right in his electorate. I thank all the housing staff in the Department of Housing, Local Government and Community Development, from the CEO down. The work they have done over the last two years to improve safety and stability in public housing across the board has been truly commendable.

We recognise that with access to safe and stable housing, we get better outcomes through employment and education and, of course, better health outcomes.

Coming into government we were 12 times the national average when it comes to homelessness. We were facing a number of situations where antisocial behaviour was out of control in a number of areas, housing repairs and maintenance had been virtually neglected by the previous government. We were also facing a rental framework out bush that was clearly found to be invalid under the High Court. At the moment, we are focused on improving housing across the board. We have delivered 401 houses, equalling 1,508 bedrooms, in remote areas.

We promised no more slaps on the wrist, so we have brought in consequences for repeated misbehaviours and those who are committing antisocial behaviour in public housing around the Territory. Under Labor's years of failure, we inherited a legacy of watered-down policy allowing public housing tenants that were causing problems in those houses to remain in those houses and cause further problems, not only damaging houses and committing antisocial behaviour, but causing massive disturbances and unrest in areas, upsetting their neighbours, with no repercussions from the Labour government.

We are focused on delivering greater tenant accountability. All we are asking is for tenants to pay their rent, look after their home and be a good neighbour—simple. That is all we are asking for. We are enforcing that. This is the important part of our policy moving forward. There have been 60 terminations. Some of those have been voluntary relinquishments. Given the work that the Housing department is doing there have been

DRAFT

148 formal matters now brought to the NT Civil Administrative Tribunal. We are clawing back unpaid rent with 483 homes now clearing their rent debt due to agreements to pay. Over 750 homes had ATPs, and that has been effective in reducing arrears.

We are getting on with the job. We are making homes safer and improving outcomes for neighbours.

Madam SPEAKER: Your time has expired, minister.

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

RIGHTS OF THE TERMINALLY ILL BILL
Serial 70

Continued from earlier this day.

Consideration in detail

Clause 15:

Ms UIBO: Mr Deputy Speaker, as I was saying just before the lunch break, this amendment is about ensuring that we stick to the same principle as the intention, I believe, for the overall Bill, which is to provide Territorians with choice around voluntary assisted dying. I do not believe that will be provided to all Territorians because of the wording of clause 15 as it is currently printed.

My request is that all members consider this deeply. Obviously, we provided some practical examples of why this amendment is being put forward today to improve and strengthen the build, but to create further mechanisms for the protections for all Territorians to access that important information. It is about choice and the ability to have communication, information, support and care and—we have gone to this point a few times today—consultation.

I believe the idea and principle of the Bill should be to create that provision, and each individual in this Assembly has that responsibility, of course, acknowledging that this is a conscience vote. That is what I have provided to my teammates through my leadership to make sure they all feel supported in that conscience vote, including for the amendments. Some people have already spoken about supporting this amendment for various reasons.

Going back to the clause as printed, the minister spoke in good faith. We used this term quite a few times in the lead-up to the debate on Tuesday and today to ensure that each of us is acting in good faith while acknowledging it is a conscience vote. I believe there will be Territorians who will be left behind in regard to their ability to consider a choice openly and freely, because the current clause 15 does not allow that fulsome, open and transparent ability to access choice if there is a hindrance, a blockage or avoidance because of someone's circumstances.

As we know, we are talking about particular criteria for Territorians to access voluntary assisted dying or who may choose to find out more about it. We heard from the Member for Fong Lim that if this Bill is passed, it will be quite a cumbersome process for anyone who is even thinking about voluntary assisted dying to go through that process, because the existing safeguards and mechanisms through this drafting, which are provided in other jurisdictions, are quite a high threshold.

We do not seek to change that high threshold. Through this amendment to clause 15 I seek to make sure that anyone looking to access a pathway towards voluntary assisted dying is not hindered at the first set of circumstances. That may include the residence that they have taken up, or who have no ability to be a resident in other than an institution or facility that may have its own policy in relation to or against VAD and therefore would automatically dismiss, knock out and omit that individual's ability to access further information, support and consultation about voluntary assisted dying.

Dr RAHMAN: I have to point out that one of the things I can uniquely try to bring to the Assembly, which I have tried to do throughout all the debates we have had over two years, is to genuinely talk about what the peer-reviewed literature, data, studies and case reports say, and that is important.

Our primary job in this place is to make laws. Every morning that we start parliamentary sittings, we are here to make laws for the good governance of the Territory, and it has to mean something. It cannot be the case

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that we make laws arbitrarily and blindly without paying attention to data, science, facts, evidence, peer-reviewed literature and experts. It is true that sometimes experts disagree. That is reasonable; experts can disagree.

Sometimes you can have an honest conversation about the fact that two sets of experts have two different views about a particular thing, but in my opinion we are not paying attention to actual evidence in this space. We are not the first jurisdiction; we are literally the last jurisdiction to think about legislative options to address institutional objections to voluntary assisted dying.

I have said in a couple of other speeches that I had the opportunity to listen and learn about that exact thing from cohorts of practitioners, not policymakers and politicians, but people who own residential care facilities, people who run them, people who are auspiced by religious entities, as well as nurse practitioners, clinicians, doctors et cetera about how they manage these things in practice. In Brisbane in March this year I was at the ICEL5 conference, which is the largest international grouping of people who get together to talk about end-of-life care and assisted dying and how to do it right and what you can learn.

What came across loud and clear was that institutions need to have minimum obligations to still provide information to people. That information sometimes comes from a VAD navigator service in the most bare minimum way, as I alluded to in my clause 15, but the basic standard of reasonable accommodation everywhere pretty much in the world is at least letting doctors, nurses and clinicians onsite at a facility to have a conversation. That is really all it is.

To simply say at this point, as is being said by the Minister for Health, that there is still in the legislation as it stands a specification under clause 15(2) that the relevant entity must give the resident information prescribed by regulation, that is limited and leaves a lot to chance. There are rules about what should and should not be done in care homes, residential entities and bodies corporate, and some of that is specified under the Act. We found an error today. Under the new *Aged Care Act* some of this is clarified. That is an important thing we have been able to resolve today because it will have a material impact on what we do inside care homes.

We are here to balance the rights of individuals and the rights of entities. My personal position is that although I am all about liberalism and allowing people to be able to, in a liberal democratic set-up, make a choice to conscientiously object, that right does not gazump a terminally ill patient's right to information. That cannot be reasonable.

If we are about providing Territorians with choice and we are prescribing through a government-auspiced Bill the parameters for how to do the delicate balance, we must land in the middle space of reasonable accommodation. I honestly do not table these things for the sake of looking cool. I hope that some of you will read them at some point, and I am sure a lot of you do—I know a lot of you do because you have talked to me about the bits and bobs that I table in the House.

A lot of countries and a lot of jurisdictions around the world referred to this paper when they were thinking about how to balance those rights. How do you balance an individual's right to information with those of an organisation or religious entities that do not want VAD happening anywhere near their premises? Pretty much always they land in the same place, which is understandable to not have stuff done in your facility administration wise, which is the exercise of a function under Part 4, but under Part 3 everything to do with request and assessment processes, that is just information. That is just allowing a doctor, a nurse, an Aboriginal healthcare worker—whoever it might be—to communicate the information, have the conversation.

Conscientious absolutism is one end of the scale. Non-toleration, as in the entity must do exactly what we tell it to do, is the other end of the scale. Reasonable accommodation is what falls in the middle, and when other places and all the best-practice practitioners think about this, they seem to settle on the idea that, to be honest, the kind of wording within this amendment is the more reasonable position. Mine was the more conscientious absolutism position. My version of this was to say that nothing can happen on premises, whereas the truth is the place that lands in the middle usually—I am referring to notes from the conference—requires some aspects of the VAD process to occur onsite, including transfer of patients in some circumstances, but the free communication of information, and that is the part that we will not have happen.

If you go through the hundreds and hundreds of hours of testimony that we had out bush you will see that most of those places that are religiously auspiced, even if they are the one operation in town, like a clinic or aged-care home or whatever, they do not want to get in the way of this. They are just nervous about the fact that they might have to administer VAD processes, actual end-of-life administration, on their premises—almost all of them. These are people who are social workers, nurses, patient care assistants. These are kind, helpful people in the healthcare system who basically are trying to help ill and old people. They pretty much

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said the same thing. If you go through all the testimony, there is almost nobody who ever says, 'No, nothing, I do not want to have anything to do with it'.

The closest expression you will get to that is that of some Aboriginal liaison officers we talked to in Alice Springs in the hospital who said, 'I do not even want to like have a conversation about this because it is not something I feel okay talking about'.

That goes to the gag clause 16, so I do not need to talk about it now. For everybody else, it was a clearcut case. In the dataset we collected over four months across all these Indigenous communities, basically it was, 'I am sure if it is for me. I do not mind if anyone else has it. I am happy to talk about it and have others talk about it.'

There was a laissez faire attitude about that. There are almost no stakeholders who are this dogmatic about saying no, no, no. Again, I am asking us to think about how we can be reasonable in accommodating Territorians—not Victorians where there are lots of different options or you can be taken to another facility. We have one provider in most of our cities and one provider even in our capital city on a lot of these things.

I continue to argue that this is a good amendment. It is not as libertarian as mine was but, on the balance of everything, it is important that we give terminally ill people free access to information from people who know what they are talking about. That will only happen if we, at a minimum, have entities compelled to allow people to do request and assessment processes on their premises as well.

Mr DEPUTY SPEAKER: The question is that the amendment be agreed to.

The Assembly divided:

Ayes 7	Noes 15
Mr Brown	Ms Boothby
J Davis	Mr Burgoyne
Mr O'Gallagher	Ms Cahill
Dr Rahman	Mrs Carlson
Mr Smelt	Mr Charls
Ms Uibo	Mr Edgington
Mr Young	Mrs Finocchiaro
	Mrs Hersey
	Mr Howe
	Mr Kerle
	Mr Mackay
	Mr Maley
	Mr Patel
	Mr Yan
	Mrs Zio

Amendment not agreed to.

Mr HOWE: I will not take much time because I sent out this amendment over a week ago. For those in the gallery, it is an amendment to clause 15. It simply makes clear the rights of conscientious objection to entities and the rights of residents. It attempts to clarify the reasonable steps that should be taken should a resident be at a conscientious-objecting facility, what that facility needs to do—namely, access to the VAD service and reasonable steps taken if requested by the resident to facilitate transfers for those appointments for voluntary assisted dying.

Amendment not agreed to.

The Assembly divided:

Ayes 14	Noes 8
Ms Boothby	Mr Brown
Mr Burgoyne	J Davis
Ms Cahill	Mr O'Gallagher
Mrs Carlson	Dr Rahman
Mr Charls	Mr Smelt
Mr Edgington	Ms Uibo

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Mrs Finocchiaro
Mrs Hersey
Mr Howe
Mr Kerle
Mr Mackay
Mr Maley
Mr Patel
Mr Yan
Mr Young
Mrs Zio

Clause 15 agreed to.

Clause 16:

Ms UIBO: Minister, can you please explain your rationale for including the gag clause in the Bill that will prevent clinicians from fully informing their patients all the options that are available to them medically.

Ms BOOTHBY: The purpose of this clause is to prohibit a healthcare worker from introducing or suggesting voluntary assisted dying to a person in the course of providing professional health or care services to that person. We have done that because the intention is to provide an additional safeguard to ensure a patient-led approach and process to access voluntary assisted dying. The restrictions also reduce the risks of actual or perceived influence, of course recognising that people facing end-of-life decisions may be particularly vulnerable to influence, especially from their doctors where a power balance exists, and provides greater assurance that any request for VAD is genuinely voluntary.

Ms UIBO: The irony of that if a cancer patient seeks medical advice from their doctor in relation to what sort of treatment they may or may not receive as a cancer patient, we do not expect that patient to have to bring up the types of radiology, chemotherapy et cetera. The patient does not have to know what the options are in regard to the medical treatment and the options and opportunities available to them to make an informed decision about their medical condition. Why is it the case that principle is being applied to this Bill through this legislation, particularly through this clause?

Ms BOOTHBY: That is the exact point. Doctors talk about treatments, and voluntary assisted dying is death, so it is a very deliberate safeguard put in place so that it is patient led from the very outset when you are at the most vulnerable you probably will ever be in your time on earth. It is a very deliberate safeguard put in place.

Doctors and health professionals do—and will and should—talk to them about all their treatment options, 'treatment' being the operative word, to save their life or continue their life. Voluntary assisted dying and accessing the right if you are terminally ill is just that: death. That is why this safeguard is in here.

Ms UIBO: Minister, have you consulted with the medical profession in relation to this clause?

Ms BOOTHBY: The medical profession has been in constant communication with all the various inquiries and the reports. They have been vocal in the media. I have said on record that this safeguard is not to protect the doctor; it is to protect the patient.

Ms UIBO: Thank you, minister, but that is not a direct answer. You, as the minister responsible for the government Bill standing in your name, as the Attorney-General—and your legal obligations for this Bill, should it pass and become a law in the Northern Territory. Have you consulted with the medical profession?

Ms BOOTHBY: Respectfully, the whole point of us doing the consultation through the bipartisan LCAC committee was to ensure that all consultation was done not by a minister of the government but by a committee. As the former Attorney-General, you would know the previous government set up the expert panel report. That was a very lengthy consulting period and a very lengthy report that was tabled in parliament.

Obviously, the next time we did the work was with the LCAC under the current parliament and the members who are in here today—with the exception of the former Member for Nightcliff, because she was on that panel.

The doctors, medical professionals, Territorians and every person who has any interest in this legislation had many opportunities to consult with the committee and the former expert panel. This is the Bill that I put forward. It is now being discussed in terms of where we land clause by clause.

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Ms UIBO: Given your answer and going to this clause, the way the Bill has been drafted goes against what the LCAC focused on, discussed and recommended, and clinical views. Why has this clause been drafted in this way, given it has gone against the LCAC, which was a government-led committee?

Ms BOOTHBY: It is a deliberate protection and safeguard for vulnerable Territorians.

Ms UIBO: How do you intend to monitor the impact, including this clause? Will it be genuinely reviewed?

Ms BOOTHBY: Yes, the review is enshrined in legislation. That will come up in a few clauses from here. It will be conducted three years after the implementation. That will be enough time—the AMA said it would be enough time as well—to look at the way in which it operates, the data, the lives of the people that this will impact, like their families, and have that whole process for them to do a proper full review operationally under Health and under the Act.

Ms UIBO: Will you collate data or statistics on how many Territorians will miss out on their end-of-life choice options or discussions because their doctor is legally prevented from telling them about that option in the first place?

Ms BOOTHBY: Sorry, what was the first part of that question?

Ms UIBO: Collecting data and statistics regarding this provision.

Ms BOOTHBY: In the Act, when a doctor receives a request, whether they accept or do not accept that request, they need to send that information to the review board. The short answer is yes. All that data will be collected and be reviewed after the three years.

Ms UIBO: How will that data be collected if a patient does not know that VAD is an option in the first place? Will their doctor just have a little side note to then collate their own information without telling the patient in the first place about VAD?

Ms BOOTHBY: I do not know how to answer that specifically because there will be conversations every day between patients and doctors. All I can say is that if the doctor is asked about this and they refuse or accept a request, that information goes to the review board so that data will be captured.

If someone does not know about it and it does not get raised, there is nothing to do in that case because it is patient led. There is no data to collect. It only becomes something that is recordable when the patient says, ‘Actually I want to talk about this’. If a doctor thinks of something out there with a patient, that is not for the doctor to decide whether they raise it or whether they record it. It is when the patient raises it that the doctor will record it or not, which is the data that will be reviewed.

Ms UIBO: I am asking the question because—you would probably know the context—the Australian Medical Association of the Northern Territory came out very strongly, particularly recently, with its disagreement of this particular clause. It was representing doctors, its members, in feeling like their hands will be tied in being able to provide fulsome, open and transparent medical advice to their patients.

The general sentiment was that it is not fair that doctors will be unable to provide all options to patients and for patients to then be decision-makers and have patient-led care. If that were to include voluntary assisted dying, it automatically discredits the ability for doctors to provide all options possible to a patient. That is why I am asking the questions, as I am sure you are aware. If that were to include voluntary assisted dying, then it would automatically discredit the ability for doctors to provide all possible options to a patient.

Mrs ZIO: I want to put on record my feelings about this clause of the Bill. It is a weird feeling to agree with the Leader of the Opposition on something, so I just wanted to say I will be voting against this clause in the Bill. I believe that doctors, if there is a lawful option on the table for people to adhere to, should be able to provide that information to their patients as required.

As I stated in my comment on the last clause, I do not believe that people automatically agree with something when they hear information. I think you will have the ability to take away process using the information they have and make the best decision that is available to them so I will be voting against this clause.

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J DAVIS: I have a question for the minister. Can you explain what the parameters are of this clause? For example, will a healthcare worker be able to provide public information in their waiting room? Would that information be able to actively promote VAD? Are there any boundaries to that?

Ms BOOTHBY: The Act is silent in that regard.

J DAVIS: In terms of initiating discussion, this is a concern that has been raised with me, could a poster saying, 'Talk to your doctor about VAD' in a waiting room be seen as initiating discussion?

Ms BOOTHBY: When it comes to promotional type materials and marketing, that is silent specifically, it is not under this clause. Coercion, of course, comes under other areas. But marketing of it in a doctor's surgery as an example, it is silent.

J DAVIS: I want to be totally clear that in terms of this part of the Act there would be no preclusion for a doctor's surgery, for example, to have a poster saying, 'Do you know about voluntary assisted dying? Ask your doctor about it.'?

Ms BOOTHBY: To be clear, this clause is about the health practitioner not initiating, so a health practitioner cannot initiate the conversation.

J DAVIS: Is there anywhere else in this Bill that it may be covered, when you say it is not in this clause?

Ms BOOTHBY: To be clear, this clause only kicks in when you are talking about a doctor and a patient or a health practitioner and patient. There is nothing else stopping other activities going on outside of that relationship.

J DAVIS: That was in answer to my question about is there anywhere else in the Bill where that would be covered outside this clause?

Ms BOOTHBY: No.

Ms UIBO: Can you see the point that prohibiting a medical practitioner from initiating discussion on voluntary assisted dying goes against the principle of informed consent if we are talking about giving Territorian's a choice and full rights to access voluntary assisted dying like every other Australian in the country? There is a clause that inhibits that access, and it goes against the clinical views of the expert. The LCAC report works on the independent inquiry years and years and volumes of work learnings from other jurisdictions that this clause goes against that principle of informed consent. Is there a reason for that, is it something that has just been thrown in to try to get it through with particular members on your side, or is there genuine interest in making sure that we have the best Bill possible?

I am concerned about this clause.

Ms BOOTHBY: I understand, Member for Arnhem. Thank you for sharing your concerns, but also those concerns of the people and bodies …

Mr DEPUTY SPEAKER: Please pause, minister. Could I ask the Member for Wanguri to come up and to take over as Acting Deputy Chair for five minutes or so?

Ms BOOTHBY: Thank you, Member for Arnhem, for putting forward those views. I understand that is your view and the view of some people who have been talking to you. I have deliberately put into this Bill that it is all about the patient volunteering what they want and acting in the way they want to act.

I do not think you can change my mind on it. Yes, I understand, but that is why we are in the parliament today—so we can talk about this and people can work out where they stand.

I very deliberately put this in as a protection for vulnerable Territorians. Everybody would agree that if you are facing death and are terminally ill, you are vulnerable. You are facing a conversation and thoughts you probably would never have thought of before.

It is deliberately for a patient to approach. We are not alone in this either. South Australia also has this approach. It is not every other jurisdiction, expert or doctor that thinks this. We are not alone. South Australia has the same process. This is a deliberate approach to safeguard it.

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I know that 9% of older Australians experience neglect or abuse from a carer or a service provider. That number of 9% is high. I do not think that is a risk we should take. This is all about being patient-led. That is why that clause is the way it is.

Mr O'GALLAGHER: I am a little concerned—correct me if I am wrong—that from what I have heard so far is you could have this scenario of a patient coming into a surgery, sitting in the surgery seeing a lot of marketing materials saying, 'Speak to your doctor about VAD' or whatever.

Can the receptionist or a nurse in that surgery reception area talk to the patient about that? Yes or no?

Ms BOOTHBY: No, they cannot.

Mr O'GALLAGHER: They cannot. Okay, I just wanted to make sure that is clear. I was wondering for the doctor, what is happening outside. The patient can read the material and, if they were choose to ask about it, that is okay. Is that correct?

Ms BOOTHBY: The ACT is silent on those materials. It is not within this particular Bill.

Mr O'GALLAGHER: Okay. Can you tell me what you envisage if there is a contravention within the confidence of a surgery? How do we enforce this? How do we find out about it? If the doctor is doing it and the patient does not report the doctor, we will never find out about it, I guess. How do we enforce that the doctor has illegally raised it?

Ms BOOTHBY: I will allow myself to be specific. The penalty for breaching—this clause provides that the contravention of this requirement by a healthcare worker who is a health practitioner is to be regarded as unprofessional conduct for the purposes of the Health Practitioner Regulation National Law. The term 'unprofessional conduct' in that law refers to professional conduct, that is of a lesser standard than that which might reasonably be expected of the health practitioner by the public or the practitioner's professional peers.

Mr O'GALLAGHER: I am thinking of a patient–doctor confidentiality discussion. There is just the patient there. The doctor actually raises it, the patient goes ahead, but no-one knows about it, unless someone reports it. Either the patient or someone has to report it. Does it only rely on patient reporting or do you envisage anyone else reporting? Or the doctor self-reporting?

Ms BOOTHBY: Anyone could report it, such as the patient, or they may talk to someone and they might feel uneasy with that, knowing it is wrong. They might too report it.

Mr O'GALLAGHER: In the case of when the doctor, rightly or wrongly, says that part of your options is to go through palliative care, pain management and so on and if it gets too much, you can make a choice, if you wish, to take up VAD. The doctor will have initiated that, which is wrong under this legislation, but the patient does not mind; they think it is good service from the doctor. If no-one tells anyone, is it okay?

Ms BOOTHBY: It is not okay because they are breaking the law. There are penalties for that if it is reported and caught and goes through a process.

Mr O'GALLAGHER: Personally, I struggle to see how this will be enforced and how many isolated cases where it may be. I suspect that the bulk of these things will happen. It will be like a lawyer's confidentiality with a client or a priest in confessional; these things happen. I suspect patients trust doctors better than they do politicians.

I respect the legislation and will pass the Bill, but I cannot see how this particular clause can be enforced. I think we are putting a lot of belts and braces around something we do not need to. Symbolically, we are trying to put in a protection that no-one will care about in the end, and it is an overreach of legislation.

Dr RAHMAN: Following the points raised by the Member for Karama, in making the policy choice that you actively made here to deviate from the LCAC recommendations and numerous other bodies that have suggested that do not want this clause to be included, have we considered the probability, possibility and threshold for what is required for somebody to initiate an action in relation to breaching this clause?

Ms BOOTHBY: If the patient raises it, in any way, shape or form, with their health professional, all information can flow.

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Dr RAHMAN: Maybe I did not make my question clear. I am not talking about when a patient raises it; I am saying if a doctor was to raise something, whatever happens behind closed doors may be unknown except to those two people, so what is the threshold for a third party reporting this situation? The Member for Karama rightfully pointed out that it is unlikely something could be ascertained.

Ms BOOTHBY: The reality is many things that are against the law happen behind closed doors. The other reality is that anyone could think about reporting someone to the authorities if they thought there was a problem.

Dr RAHMAN: Am I right in understanding that anybody will have standing under this Act to report a potential breach of this provision to NTCAT, pursuant to all the other protocols in the later part of this?

Ms BOOTHBY: Someone still needs to have standing. If it is a patient who makes a complaint, or a patient's family member, that would have standing.

Dr RAHMAN: These are defined within the legislation. If the patient does not report it, it is clear that the only other person who can report it, based on your answer, is a third party. Is it reasonable to say that the only way this provision can be enacted and enforced—enforceability was the point that the Member for Karama raised—is if a third party intervenes to frustrate a process?

Ms BOOTHBY: The process that you describe is the correct process. If a doctor breaches this then the patient can make that complaint and report about that process. Yes, you are correct.

Dr RAHMAN: Following on from the same point, am I clear in understanding that you are confirming that the only way if a patient does not raise this that this provision can be enacted and enforced is by a third-party intervention to frustrate what has happened behind closed doors?

Ms BOOTHBY: It is frustrating the process, but it is also illegal, so that is where this comes into it.

Dr RAHMAN: I do not want to be a stickler, but the point is that all the literature in this area suggests that whilst gag clauses are well-intentioned measures, which in 2017 were put in place in Victoria to try to ensure that nobody ever made a decision under duress. All of the case report data says that the only time they ever come into effect is when a third party takes umbrage at a perceived breach of the law whether or not there was said breach of the law. Are we essentially agreeing with that position and in spite of it putting a gag clause in place?

Ms BOOTHBY: To be clear, we have put this in here as a protection so that it is patient led. Whatever happens it is patient led. The mechanism of a doctor raising this and basically breaking the law, anyone, either the patient or another doctor who knows him and knows his types of practices, or someone in the surgery can complain, make a report about something they think they are doing that is illegal and that goes through to AHPRA to make that determination. It is a normal process where complaints can be made about doctors and their practices.

Dr RAHMAN: There are a couple of parts to your answer that need to be picked apart. There has been a conflation of when we are talking about healthcare workers versus health practitioners. If someone is a healthcare worker as is broadly defined in this section, that does not necessarily cover somebody who is subject to sanction as a practitioner under AHPRA. What is the penalty for a healthcare worker who raises these things?

Ms BOOTHBY: The legislation sets out the guardrails for practitioners to operate within. There does not need to be a police investigation. They can still complain to AHPRA whether they are practitioner or a health worker; it is the same funnel.

Dr RAHMAN: Is it the case then that the legislation is silent on any penalty for breach of this offence for a healthcare worker, because if so—again, this goes to the Member for Karama's point—this clause is raising more questions than answers now, and these were not even the questions that I had. I just do not think it is an enforceable provision at this point if there is no penalty associated with it.

Ms BOOTHBY: It all depends on the case, and the penalty will be determined by the right law. There is Health Practitioner Regulation National Law, doctors have codes of conduct and there is a heap of professional standards that doctors have every day for lots of different practices, so it would just refer to those same practices.

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Dr RAHMAN: Respectfully, I am not talking about a doctor or a practitioner. I am talking about a healthcare worker who falls outside the scope of that as defined in your definitions. It could be an Aboriginal liaison officer or any number of people who provide services under this Act.

Ms BOOTHBY: A healthcare worker, in this Act, is defined in clause 5 to mean a health practitioner or any other person providing health or professional care services. Health practitioner is also defined in clause 5 to mean a person registered under the Health Practitioner Regulation National Law to practise in a health profession, other than as a student. That is where it goes back to that.

Dr RAHMAN: To that point, paragraph (b) of the healthcare worker definition states:

any other person who provides health services or professional care services.

Those people are not health practitioners and are not subject to any of the enforcement provisions contained within the Act, if that is the case.

Ms BOOTHBY: The other avenue for complaint is the Health and Community Services Complaints Commission.

Ms UIBO: My question is from a thought that came from the Member for Karama's question. We have just talked briefly about the definitions. The Member for Karama posed the question to you that if voluntary assisted dying material was in a reception, could the receptionist or the nurse raise voluntary assisted dying as an option? I think you lumped that in as one response and said yes or no—no.

Given that the nurse would be covered under the definition of 'healthcare worker' or 'health practitioner', what provisions would apply to a receptionist or an admin officer who, to the point the Member for Fong Lim raised, would not be covered under any of those provisions for health workers, doctors or medical practitioners as administration officers?

Ms BOOTHBY: To be clear, this prohibition applies to a healthcare worker. This term is defined in clause 5. It includes registered health practitioners such as doctors, nurses, Aboriginal health practitioners and pharmacists. It also includes any other person who provides health services or professional care services. This includes people who are employed to provide the person with support, personal care such as assistance with meals and showering or disability services. The intention is to capture a wide range of workers in their professional capacity as a service provider to the person, but it does not extend to their friends and family.

Ms UIBO: So under that definition, that would then omit an administration officer/receptionist through the definitions that were defined just then by you. It sounds like a receptionist or admin officer would not be captured by any of this clause and the provision's definitions, so they could raise voluntary assisted dying in the reception waiting room because they are not a healthcare worker and do not provide health services or professional care services under the definitions that you have outlined. Is that correct?

Ms BOOTHBY: That is correct. I am trying to think of the flip side.

J DAVIS: I want to clarify that because I think earlier you answered the Member for Karama when he asked you that question and you said that they cannot give information. Is that right? You are now saying yes.

Ms BOOTHBY: Just to clarify, the Member for Karama was talking about the nurses, and I did not pick up on the other part, sorry. The Member for Arnhem was able to clarify when asked by the reception and that is not covered.

Mr CHARLS: Another thing everyone is talking about is the health care workers. I was working as a health care worker before I was a registered nurse so there is a scope of practice for each health care worker. I do not think there are. I heard about members of this Chamber talking about the receptionist and other people talking and initiating this discussion; that is not within their scope of practice, and I just want to add that comment. Each health care worker has a scope of practice and when it comes to the doctor, that is almost wider and they can talk about the treatment options. In my experience of nearly 14 years in the health system, I do not believe that I have seen the receptionist initiating a conversation or anyone who is providing the care initiating that conversation. That is why we have a code of conduct and the scope of practice for each position as well.

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Mr O'GALLAGHER: Can you clarify again please. The receptionist if they did choose to do so, regardless of whether they do it normally or not, could actually raise the option of VAD with the patient prior to them going to see the doctor? Yes or no?

Ms BOOTHBY: The staff of the surgery for this example that you have put forward to me, if the doctor knows that they are not to raise issues, and then they do, then that would be a disciplinary action for that practice.

Mr O'GALLAGHER: As you know, I have a little bit of imagination here, so let me just think of a couple of scenarios, please. We are allowed to do hypothetical in CID, for those who may not recall. Suppose that some organisation like COTA organises a seminar on treatments for terminal cancer. That is the topic, treatments for terminal cancer. They get in 20 or 30 patients; some of those may be suffering from terminal illness, and the guest speaker is a doctor. Nothing has been said but during that presentation the doctor firstly goes through all the others, palliative care, and then raises you could also do VAD if you choose, and this is the option. Are they in breach by talking directly to patients without having the patients initiated?

Ms BOOTHBY: Yes that can happen. The reason is it because it is not a patient/doctor or patient/health care worker relationship.

Mr O'GALLAGHER: This is a doctor talking to a group of cancer patients.

Ms BOOTHBY: Yes.

Mr O'GALLAGHER: They would be in breach?

Ms BOOTHBY: Sorry, the opposite. No, that is not a breach.

Mr O'GALLAGHER: The doctor can raise it to a group of patients without any problem in that sort of scenario, but in the surgery they cannot talk one-on-one? Is that correct or not?

Ms BOOTHBY: They are not their patients.

Mr MALEY: It would be like the doctor walking down the mall and going yes with a group; they are not patients where they have gone and booked in with the doctor. That is when that confidentiality comes into play.

Madam SPEAKER: Member for Nelson, the questions are not directed to you, they are directed to the Attorney-General. I am sure she appreciates your help.

Mr O'GALLAGHER: As a follow up, if a doctor puts out a post saying these are the treatment options for patients with terminal illness, and as part of that post they also include the VAD option, going through palliative care and all that stuff. Patients will see that. Is that in breach or is that okay or is that just marketing?

Ms BOOTHBY: That is okay.

Mr O'GALLAGHER: What I am trying to say is that there is a very fine line here and with all due respect, I keep saying I think this clause is an overreach trying to use a sledgehammer to knock over one very isolated nut that may or may not occur. It just not seem right to me but with all due respect.

Mr SMELT: Have you discussed clause 16 with Dr John Zorbas or other representatives of the Australian Medical Association?

Ms BOOTHBY: I have not had a conversation with Dr John Zorbas, but I know he had many conversations, including throughout the consultation. I want everyone to remember, and not lose sight, that this is deliberately being put in for a patient-led discussion so that there is no coercion at all.

Mr SMELT: Or any other representatives from the AMA?

Ms BOOTHBY: The consultation was all part of the LCAC report, plus I also looked back at the expert panel as well. That is where all of the consultation happened. It was a deliberate move to send that to that committee, as a bipartisan committee, to get out to our communities and consult

Ms UIBO: With some of the responses that have just been provided, effectively clause 16 could be worked around or overridden through the examples that we have discussed in practicality. And example is if a general

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practitioner has an administrative officer or receptionist who provides information to a patient, who then comes into a GP confidential one-on-one patient care consultation.

This convoluted clause 16 should be null and void in the first place. Everyone should be provided with the options afoot anyway, as opposed to who can and cannot speak—having what everyone is calling—I reiterate—the gag order for medical practitioners, health workers and health practitioners versus who could then offer information about voluntary assisted dying prior to a medical appointment or a medical consultation.

In this little can of worms, which was kindly opened by the Member for Karama is a bit of a fishing expedition right now. It does not make sense to have this clause in place now, based on all the responses and on what now could easily be worked around or boycotted as a process to protect the opportunities that people may want to see and have with access to information for voluntary assisted dying. I am making that point. It is quite wild, to be honest.

J DAVIS: How can a discussion, be patient-led if the patient does not have all the options in front of them?

Ms BOOTHBY: I respectfully disagree that all of the options include death when we are talking about doctors who care for patients. This has been so widely discussed in the community across the world and in the nation, there would be few people who would not know about VAD in the first place.

J DAVIS: I hear that is your opinion. Is that based on any evidence?

Ms BOOTHBY: The evidence that I have about this particular clause is the 9%, as an example. The Australian Institute of Health and Wellbeing records that 9% of the elderly people who are either abused or neglected, the perpetrators are their carers and service providers. This is an important piece of legislation that we are respectfully debating today and asking lots of questions that need deliberate protection and safeguards for those vulnerable people.

This clause has been inserted so that it is patient-led wholly and solely. Then, once the patient raises that they would like to access their death sooner—that is what they will be asking for, 'I want to die sooner'. The doctor will then provide them that information and help and support them through that process because that is their right under this law.

J DAVIS: My question was actually about what evidence—your statement about the majority of people knowing about voluntary assisted dying, so would know to ask.

Ms BOOTHBY: I feel like I have answered that question. I do not want to keep repeating myself over and again.

J DAVIS: You have answered the question about the evidence that most people know about voluntary assisted dying and therefore would know to ask. Just to clarify, that is the question that you believe you have answered?

Ms BOOTHBY: I do not have any further information that I can add. I do not have that information.

Dr RAHMAN: I have circulated an amendment about this, because I genuinely believe that patients should not get advice from anyone shooting from the hip, whether they are a healthcare worker or practitioner, unless they actually know what they are talking about. The discussion that has ensued, some of it has been beyond what I had countenanced at all, but what it is exposing to me quite clearly is that in its current form, this is a legally unenforceable provision. As the Attorney-General of the Northern Territory, is that not a problem? All I can see that we can do is provide a third-party frustration and potentially vexatious claims to clog up NTCAT on this issue. Can you identify how this is a legally enforceable provision, given the breadth of people who can make comment on this issue without any parameters, the legislation being silent on any parameters?

Ms BOOTHBY: That is your opinion on this. There are clauses in here, and I have explained how it works with the penalties.

Dr RAHMAN: To the earlier point that was raised by the Member for Johnston, the only evidence that you have provided to indicate that people are aware of VAD and/or this must be patient driven is the elder abuse research that you cited. Would it be helpful for us to discuss some of the mountain of other evidence that suggests the antithesis of that?

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The body of evidence and literature on the amendment in issue is overwhelming, not from peak advocacy groups but across the board. If we are making such a consequential decision as this, would it not be prudent for us to consider the many other pieces of evidence that suggest in practical terms gag orders serve only to frustrate these processes, not protect patients from being patient led in a discussion?

Ms BOOTHBY: I think I answered your question already and you are proposing to go through more information. I am happy to answer those questions if you need me to, but I do not think you asked a question.

Dr RAHMAN: I probably asked the question poorly. My apologies; that was not my intention. I think your answers to the question have provided, at this stage—unless I have misunderstood it—no evidence to substantiate the basis for the policy position, whereas there is a mountain of evidence to suggest that gag clauses should be rolled back because they do not serve patients; they serve only for third-party frustration. That is the point that all your answers seem to confirm.

Ms BOOTHBY: I respect yours and many other people's opinion about this. There are many other people who believe that having these protections in this Act is important, and it is the most important thing to them, and we cannot lose sight that not every jurisdiction is saying that they should not have health practitioners raise this. South Australia is the same as this piece of legislation.

Dr RAHMAN: Are you aware of the review and process discussions in South Australia pertaining to the rollback of the South Australian gag clauses?

Mr MALEY: These questions are not relevant to the clause. We are talking about things in South Australia when talking about the clause. We are going down a path which is not relevant to the actual clause.

Madam SPEAKER: I would see it as relevant to the clause.

Ms BOOTHBY: I am aware of the discussions happening in South Australia. They are just discussions at this point. We are here to discuss what is on the table. I respect the amendments that have been put forward. I am happy to debate and support or not support those amendments. I have made my position clear on this. I am happy to take more questions.

Madam SPEAKER: In a unicameral system we do not have an upper house to scrutinise Bills. This is the place to scrutinise each clause. What we are doing is reflective of a good healthy process.

Dr RAHMAN: Madam Speaker, could you please reiterate that? We could not hear.

Madam SPEAKER: I said that because we have a unicameral system we do not have the second layer of scrutiny that other parliaments have. Consideration in detail is effectively that important part of the process. Given the profound nature of this Bill, I think we need to allow a certain amount of latitude when we are scrutinising each clause. That is in response to Member for Nelson's point of order.

Mr O'GALLAGHER: This is a practical scenario. A patient goes to see a doctor in Timber Creek. That doctor is not allowed to initiate a discussion on VAD, unless the patient does so. That same patient goes to Kununurra and meets a doctor, and the doctor initiates it and that is okay. Is that correct, or have I missed interpreted that?

Ms BOOTHBY: Yes.

Mr O'GALLAGHER: You can understand my confusion. You can go a couple of hundred kilometres and get a different response. It is illegal here but not in Kununurra. We will be the only ones where it is illegal. That is what I am concerned about. How do we enforce this? I do not have a problem with the Bill, and I fully respect you, but I have said before I think the intention of this clause is good, but I cannot see how it can be enforced. I am worried that we are introducing a clause and overreaching legislation. That does not make sense to me.

Mr CHARLS: There are 16 professions that are registered with AHPRA. There are other professions like sonographers, audiologists, speech pathologists and social workers registered through other processes. For any of those 20 professions, 16 from AHPRA and four others, that are referred to if there are breaches of this, will there be consequences?

Ms BOOTHBY: If there are any professional breaches, there will be a disciplinary complaints process through AHPRA.

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J DAVIS: Just to clarify, would that include social workers, as the Member for Sanderson said?

Mr CHARLS: Madam Speaker, can I clarify?

Madam SPEAKER: No. The questions do not go through you, Member for Sanderson. You can speak, but the questions go to the Attorney-General.

Mr CHARLS: I did not say 'social worker through AHPRA'. Social workers have a separate body, the Association of Australian Social Workers. Social workers, speech pathologists, audiologists and sonographers have their own professional bodies. I referred to the 16 professions under AHPRA. That is an entirely different thing.

Madam SPEAKER: Questions have to go through the Attorney-General. Anyone can make a comment, but if there is a specific question, it has to go to the Attorney-General. Do you have another question, Member for Johnston? The Attorney-General is preparing an answer.

Ms BOOTHBY: Member for Johnston, I am actually not sure if social workers are on the list that the Member for Sanderson is talking about. I am not sure if he has a list. I do not have that list here. That obviously sits under the Health portfolio specifically, but what I can say is the prohibition applies to a healthcare worker, and this is defined in clause 5. It includes registered health practitioners such as doctors, nurses, Aboriginal health practitioners and pharmacists. It also includes any other person who provides health services or professional care services.

This includes people who are employed to provide the person with support, personal care such as assistance with meals and showering or disability services, and that the intention is to capture a wide range of workers in their professional capacity as a service provider to the person.

J DAVIS: So that list is obviously not exhaustive. I think you said you cannot answer, but just to clarify, would that include social workers?

Ms BOOTHBY: No.

Dr RAHMAN: When the LCAC inquiry was conducted, one of the great sources of fear, particularly out bush, was that we would have the wrong people raising these issues and creating more harm than good. The totality of the answers that you are providing seems to suggest that this clause is operationally unenforceable and that just about anyone can raise anything and do so without consequence, except under the under the context of a professional accreditation body.

The Member for Sanderson pointed out how each profession is a regulated profession and there are provisions associated with that. If the only consequences that are itemised in here pertain to medical practitioners, are we providing adequate penalties in this to ensure that people do not raise these issues? Because at the moment it would seem that only health practitioners regulated under the health practitioners Act are subject to consequences for a breach of the Act herein.

Ms BOOTHBY: Yes.

Dr RAHMAN: Was that the answer to your question?

Ms BOOTHBY: Yes. You asked if it was adequate. I said yes.

Dr RAHMAN: Attorney-General, sorry, can I just clarify? Did you just confirm that the Act is operationally unenforceable in relation to …

Ms BOOTHBY: No. Sorry, you asked me two questions. The answer to your last question was yes.

Dr RAHMAN: Could you just repeat what it is that you are confirming.

Ms BOOTHBY: Confirming that there are mechanisms for penalties for reporting throughout the medical professional field.

Dr RAHMAN: But those consequences only pertain in this Act to doctors.

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Ms BOOTHBY: And they are adequate. Sorry, that last part

Dr RAHMAN: So anybody else—I did not even think of a receptionist. The social workers have their own accreditation body, and the Member for Sanderson identified a slew of professional accreditation schemes—sorry, not accreditation schemes, but regulatory schemes and governing bodies' practices. You have essentially just clarified that this is an operationally unenforceable clause and that anyone can bring these things up.

Madam SPEAKER: Yes, just pull back from there, Member for Fong Lim.

Dr RAHMAN: Sure. Okay. Sorry. What I am trying to understand is this: what are the limitations then or what can be set? Because at the moment the scenarios that were painted by the Member for Karama, along with the questions raised and the answers provided, make it clear that there is a wide berth of what can be raised without consequence.

Ms BOOTHBY: I do understand what you are saying, but this clause is very specific to regulate the healthcare workers, whether they are raising or not raising their conversation about VAD with their patient. That is why in this clause it says that you cannot do that.

Dr RAHMAN: Attorney-General, respectfully, the clause is specific to healthcare workers. As we have just expanded on, healthcare workers is an enormous body of people. So, an enormous body of people, we are saying are not subject to consequence unless they are a medical practitioner or regulated under AHPRA.

Madam SPEAKER: I will let the Attorney-General answer the question first, then I will go to Member for Port Darwin. Attorney General.

Ms BOOTHBY: I already went through the list of people who it captures, in terms of healthcare profession professionals and workers. It is those people this clause relates to who a person will be having conversations with, about very specific health treatments when they are facing a terminal illness.

Ms CAHILL: Attorney-General, I seek clarification. The enforceability sits to those who are registered and beholden to the Health Practitioners Regulations and Act, the AHPRA scheme. In which case that is a very extensive Act. It is not just restricted to medical practitioners. The definition of health practitioner would cover anybody who was listed as being registered under the health practitioner legislation, which includes paramedics, pharmacists, physios, podiatrists, psychologists. There is a whole list of people have. Am I understanding that correctly, Attorney General?

Ms BOOTHBY: Yes.

Ms UIBO: I think it is very clear there are those guidelines around health practitioners. To the crux of the point, originally made by the Member for Karama, if someone who is not a health practitioner, who is working with health practitioners or health workers, provides the information about voluntary assisted dying, is there an enforceable penalty under this clause? Therefore, is it null and void?

In this clause, a person such as a receptionist or administration officer in a health clinic, hospital, AMS, general practitioner's office or workspace, under this proposed Act does not apply. Therefore, there is no enforceability, penalty, provisions, ways to complain or report to NTCAT, if someone working within the health field, who is not a health worker or practitioner, raises voluntary assisted dying. Based on the current wording of this clause.

Ms BOOTHBY: If there is a complaint or report of a health worker doing the wrong thing under this clause, then they can make complaints to AHPRA, if that is their body, and the big, long list that I do not have, or they could make a complaint to the NT Health Complaints Commission. That is the process they go through. Doctors and health professionals all have their own codes of conduct as well.

Ms UIBO: Thank you, Minister, I think that has been well established through this line of questioning.

My question again, does clause 16 apply to administrative officers and receptionists who work in health?

Ms BOOTHBY: No.

Ms CAHILL: Attorney-General, on that point, I ask for clarification. Health practitioners under regulations are required to adhere to all laws in place in the jurisdictions they are in, including, for example, compliance with

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reporting of domestic violence and a whole bunch of other stuff. If it is a doctor, for example, working in a general practice, they are required under law to report that. A breach of that would be considered a breach of their obligations as registered health practitioners. To clarify, you indicated in response to the question that people working under those regulated health practitioners may not be required to follow the same rules. However, there is an accreditation process that applies to hospitals and medical practices across Australia—for example, where every person working in that hospital is meant to comply with all the policies in play for the safe operation of whatever services they are providing.

Are you saying that in needing to make sure that they comply with regulations—that includes the supervision of people working under them—they would not be pulled in under the accreditation and their practitioner requirements?

Ms BOOTHBY: This legislation does not specifically say that. As you have alluded to, other accreditations, regulations and Acts fall under that kind of work those people do in those practices. Quite possibly like other treatments, it would be captured there as well.

Mr MACKAY: It is important to go back to what this clause is about. It is that a healthcare worker must not, in the course of providing a health service or professional care service to a person, initiate that discussion. That is an important protection. The views in my survey and the people I have talked to—it has bounced back and forth; there are many who see this as a gag clause that has been initiated, and others who see it as a careful protection that makes sure that when you are in a room with your doctor, you are the person who says, 'Let us consider that'. That is it.

Whether there are loopholes or the receptionist is covered, to me it is disingenuous to argue that this clause does not go far enough in stopping conversation when all the amendments that have been circulated and will be proposed are trying to remove this clause. To me, it is trying to white-ant what is basically a simple protection; that is, the patient must be the first person to say, 'Hey, doctor, I want to consider that'. There can be signs in the lobby, 'Talk to your doctor about VAD'. We have heard organisations can provide information freely. We heard all of that. This is about you in the room with the doctor. You have been diagnosed with something terminal and you have made the decision to say, 'I want to talk about that'.

It is my understanding, from listening to the speeches on Tuesday, that there is fear in remote communities that if a doctor was to initiate that discussion, there may be concern that the community would stop going to talk to that doctor. There are concerns that you go there to die. That common theme was raised time and again and why, in the remoteness and the Aboriginal context, we have to make sure that the person who initiates that conversation is the person who is requesting the service.

For me, this is why this is such an important clause—that it is your choice to activate this option and get the information. Similarly, by removing this clause people do not know whether their doctor is a conscientious objector. If they go to the doctor and the doctor never raises it, they might think they are not eligible. They need to know to ask. When you are in that room with your doctor—somebody you trust, who provides you with medical advice—you take what they say seriously. It is your decision to initiate that conversation. For that reason, I will be supporting this clause.

Dr RAHMAN: I am tired and confused already. Are we, at this stage, allowed to discuss the broad parameters of this clause without view to amendment? This is just a discussion about the parameters of the clause; is that correct?

Madam SPEAKER: Yes, that is correct. It is not a group discussion, but you can stand up and make a comment and ask a question.

Dr RAHMAN: That is what I was trying to …

Madam SPEAKER: It is not a therapy session.

Dr RAHMAN: No, I appreciate that …

Madam SPEAKER: I know you are not implying it. I am being facetious.

Dr RAHMAN: No, I am not implying that. My point is that I think the Attorney-General has tried to answer a lot of the questions that have been raised as clearly as possible, but there is other information that could be imparted in the debate. The Member for Goyder has just done some of that. Is it in order to introduce information as part of the debate or the discussion on this clause?

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Madam SPEAKER: Yes. The answer to that is yes, if it is relevant.

Dr RAHMAN: Okay. To that point then, if I may, on Tuesday everybody gave speeches regarding having consulted with their community. Everybody talked about consulting with their community. Everybody talked about combinations of doorknocking, letterboxing, online surveys and trying to understand from your electorate how many people supported these kinds of initiatives. The Member for Goyder has just alluded to the fact that he has also gotten feedback from several people.

Without wanting to interrogate his dataset my guess is the sample size for that is low and probably in double digits and no higher unless I can be corrected. In that regard, if we are looking for data to be able to evidence whether people want to initiate these conversations, yes or no, we have to turn our minds to publicly available data that he is saying that people overwhelmingly do want doctors to raise these matters.

I have tabled for the Assembly the most comprehensive study done in Australia to date on public views about doctors roles and facilitating access to VAD which was done in Queensland, which has a sample size of more than 1,000 people—which I think is safe to say is larger than any of the consultation any of us have been able to achieve, even if you combine every single bit of consultation you have done—and it overwhelmingly concluded that the majority of survey participants want doctors to raise VAD if they were potentially eligible and supported requiring conscientiously objecting practitioners to provide contact details for the state VAD support service.

There are some clear bits of evidence saying that gag clauses were well-intentioned 10 years ago to protect patients and to allow them to initiate, but there is a ton of evidence here that is saying to us in practice it has caused people to be frustrated by third parties of which we have heard the possibilities are enumerate today and we have also heard that a range of other health workers could raise these issues with relative impunity other than by sanction from their professional accreditation body but not under criminal sanction for example.

That says to me that this clause is not achieving its function and it actually makes me all the more comfortable with what I have suggested in amendment which we are not discussing yet. The point is that only people who know what they are talking about should be saying anything otherwise nobody should be saying anything. That is clearly spelt out in two of the amendments. I personally think my one is superior to the Member for Arnhem's version, but again, my point is that we seem to be agreeing in this House on the fact that nobody should be leading a conversation unless they know what they are talking about. The clause as it stands, on the totality of everything that we have heard, makes it super clear that it is not going to be the case.

We heard the example of social workers, which is a very good example. It appears that social workers could fall through the cracks on this; that is an obvious highly skilled regulated profession that discusses these issues client-facing. The ones we have been thinking about all these times are Aboriginal liaison officers, patient care assistants and translators even. It is clear to me that operationally this clause cannot fulfil its stated policy objective aligned to what the Attorney-General has said. I cannot believe I am saying this, but I think we are actually agreeing that nobody should say anything unless they know what they are talking about. To that extent, I think that both sets of amendments we have are worth having a think about because they tighten up legally what is clearly a hole at the moment.

This partly a problem where we can take some blame for this from the LCAC report frankly. There was a lot of talk about practitioners versus healthcare workers versus doctors versus nurse practitioners, and it is hard to harmonise all of that. I think the drafters have done a sterling job of trying to do that. I am certain now they have not covered the field. We have already gone past clause 5, but we could come back to redefine healthcare worker, healthcare practitioner and people under regulated professions because at the moment some of that is logically inconsistent.

If you look at clause 16 as it stands, it is a blanket, 'Healthcare workers may not initiate discussion' and then we realise that we are covering a super wide scope of people that are healthcare workers and then part three of that is essentially the only boilerplate part that has been imported from other jurisdictions to say that the only real consequences though are for a healthcare worker who is a health practitioner and that is to be regarded as unprofessional contact if they contravene subsection (1) within the meaning and for the purposes of the Health Practitioner Regulation National Law. That law does not cover a tonne of these people we are talking about, so I am not saying that this is a face reality moment for us in the Chamber.

The policy position the government has made on the basis of what evidence it has considered is super clear. The Attorney-General has made it super clear, and I think that is fair. She said that she wants to protect patients for these conversations to be patient led and, basically, for people who do not know what they are

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talking about to not say anything— to allow people to initiate it before a conversation can be can be expanded upon.

The policy position is clear. The discussion surrounding clauses made it clear that operationally this is extremely unworkable, arguably. You can debate it as a point of law. The Member for Goyder made a point that in his consultations, in his survey set of people from the electorate of Goyder, there is a sense that people should be able to lead this process and not operate under duress if that is what we want. We pay attention to a version of a survey of 1,000 people of this.

We should be supporting this amendment, either of the two of them, frankly, which provide much more clear-cut guidelines on who can say something when, and what they can say. Otherwise, this is a giant can of worms, and the only thing that can potentially happen with this is third-party litigation. There are so many ways to prosecute. Member for Karama, I had not thought about receptionists. There is a wide range of things being countenanced here, but there are definitely ways to frustrate a terminally ill person.

If we go back to the principles of the Act, it is basically to allow terminally ill choice and freedom to access VAD and the information and processes within constraints. We balance that out. But this will not allow that to happen. If we want to protect the vulnerable and ensure that only people who interact with patients who know what they are talking about are able to say something, we have to seriously move past one of these sets of amendments or we must amend in a new or novel way. Attorney-General, if you are considering that in any form, I would 100% support, in the same spirit that this morning, when we made the amendment in clause 5—better that the Attorney-General of the House move the amendment on a government Bill and we get behind it.

I would encourage everybody to seriously think about the fact that these amendments will need to be passed in some form if you want to protect patients from being misled by any number of people without consequence. I do not want to move immediately onto my amendments, just in case there are other questions, so I will be seated at this point to allow other questions, but I am happy to proceed on to amendments at some point. At this point the substantive information—I am up anyway.

I have one minute 50 left, so I will simply point out as well that regarding other states and territories, it is only South Australia where health practitioners are prevented now from raising VAD. And it is true, Attorney-General, they may or may not change that. But again, that might be a coin toss. The research evidence, which we could pile in if we wanted to but is not helpful now because we have bigger problems, is that gag causes impact discussions between patients and practitioners and result in problems for medical practitioners in particular and third-party interventions.

The VAD board in Victoria and the five-year review of the VAD legislation included tonnes of evidence about this. Can I table a document in consideration in detail? No, I cannot. I am sorry. Thank you for clarifying that, Clerk. I will raise it in a substantive speech when I am speaking to the amendments if necessary so that we have the references, but there is an inordinate amount of evidence to validate the fact that gag clauses do not do what they were supposed to do 10 years ago. If they don't do what they were supposed to do, and if we really want this to be patient led and do not want anybody saying the wrong thing, we must consider amending clause 16.

I do not care if it is my amendment, but I want it to be. If it is not, I really do not care. Attorney-General, we must amend this clause, in this in in my opinion, and on the totality of everything we have heard in here …

Madam SPEAKER: Member for Fong Lim, you can seek leave to table a document if you want.

Dr RAHMAN: Okay. I seek leave to table this academic advice on research on prohibition, raising VAD and time limits until death, pertaining to regulating conversations about assisting death, including prohibitions, and also raising issues associated with included timeframes.

Leave granted.

Mr EDGINGTON: I want to speak briefly in support of the clause as it stands. I will start with outlining one of the Principles of the Act in clause 4. It is an important place to start:

a person should be protected from coercion and exploitation;

If we look at clause 16:

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A health care worker must not, in the course of providing a health service or professional care service to a person:

(a) initiate discussion with the person that is in substance about voluntary assisted dying; or

(b) in substance, suggest voluntary assisted dying to the person.

It goes on to say:

Subsection (1) does not prevent a health care worker providing information about voluntary assisted dying …

And:

A contravention of subsection (1) by a health care worker who is a health practitioner is to be regarded as unprofessional conduct within the meaning and for the purposes of the Health Practitioner Regulation National Law.

The definitions in this clause are broad definitions. If I go back to the clause of a health worker, it clearly says that—I will get to the main point about this—a healthcare worker is a health practitioner or any other person who provides health services or professional care services.

The point I am getting to is professional care services means any of the following provided to a person under a contract of employment or a contract for services. This talks about somebody providing support or assistance, personal care, disability services, and goes on to subsection (d) anyone providing services provided by registered NDIS provider within the meaning of the National Disability Insurance Scheme.

My point is that this clause is patient-led because this is about the patient's right to decide how they die. It makes sense that they should initiate the conversation, not a doctor, a carer, a family member or other agent, an NDIS provider, a support worker or a personal care worker.

This clause is designed to provide that protection to vulnerable people in the Northern Territory. We want to make sure that we do not open the door to subtle coercion if it is not patient-led. Once a patient suggests or asks for it, then all of the information will be provided to them.

This safeguard is a protection against coercion, pressure and exploitation. The Australian Institute of Health and Welfare said that 9% of harm or neglect against older Australians is perpetrated by their carer or service provider. They are in those definitions.

It is important to remember the name of this Bill is the Rights of the Terminally Ill Bill. I point out the rights belong to the patient, not the doctor, the support services, the professional care services or the healthcare workers.

The Australian Psychological Society made a submission. They said that robust provisions need to be in place to ensure protection from coercion from family members, carers, health professionals and others. They are the ones that are picked up in those definitions that I referred to.

The legislation does not prevent healthcare practitioners discussing diagnosis, prognosis, treatment options or palliative care. It simply prevents practitioners from initiating substantive discussions about voluntary assisted dying.

I said in my speech the other day concerns have been raised in reports. If we go back to the report of the session which was chaired by Vicky O'Halloran, cultural issues relevant to VAD were clearly discussed in that report. A lot of that is outlined in Appendix 9.

These are important because remote Territorians have fears of coercion or worse. Consultation found some patients misinterpreting clinical advice as an actual recommendation from their doctor. This is why, as I said, we have the patient-led model. It strengthens trust in the process, medical advice and legitimising the patient's independent voluntary decision.

Central Australian Aboriginal Congress raised fears amongst Aboriginal people that they may be coerced into agreeing with VAD and concerned they might avoid healthcare because of those fears. AMSANT pointed

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out, that in some cases, Aboriginal people were afraid of accessing healthcare because of fears of being euthanised without their consent.

We need to make sure our hospitals and clinics are not associated with death and trauma, so people seek help for health concerns to get better, not ignore health concerns so they get sicker and seek help too late.

There are also concerns, in some contexts, for remote Territorians that having conversations about death may be taboo or cause concerns about cursing, bad luck, or black magic.

NT Health—our intention is to work with Aboriginal organisations to ensure culturally safe implementation of VAD.

There are some sick people who struggle to get help when they need it and are fearful of attending local clinics. This clause is designed to assist, prevent and safeguard remote Territorians from coercion.

The Territory is not South Australia, New South Wales, Queensland or Victoria. This is the Territory and these are the real issues I see every day of the week. No doubt, there are other remote members in this Chamber who see and hear the same things I do.

I support the clause as is because it provides protection for Aboriginal Territorians in remote areas of the Territory.

J DAVIS: Thank you for putting those important views on the record, Member for Barkly.

I address one of the things you said repeatedly when talking about coercion. There is a complete difference between coercion and providing information. I think Council on the Ageing put it very clearly when they talked about their concerns about preventing a doctor from raising VAD as an option.

They said, and I quote:

> *preventing a doctor from raising it with an eligible patient is a significant limitation on informed decision making*

Information is not coercion. Patients deserve to be properly informed so they can make decisions that reflect their own wishes and values. To legislate that a doctor cannot inform patients about all their choices appears tantamount to censorship.

I have no argument with you, Member for Barkly, that we need far better cultural safety for people in our communities, that includes often in the health profession. But that is not an issue limited to this bill. The way to address that is not to impose a gag clause on doctors. The way to do that is make sure people are properly culturally informed, and when we address this clause we put things in place to make sure, as the Member for Fong Lim has said, only people with the appropriate information, knowing how to talk about these things appropriately, raises it with their patients.

Madam SPEAKER: Can I ask you to direct your comments through me, as the Chair. It is feeling like a group discussion and we need to keep it as strictly consideration in detail.

Mr EDGINGTON: Can I respond to that, Madam Speaker?

Madam SPEAKER: This is where we are getting into the group chat sort of thing. Just to diffuse this process a bit, I will let the Opposition Leader speak and then you can have your turn, Member for Barkly.

Ms UIBO: Through the Chair, the wording of Clause 16, I do not believe it is fit for purpose when we talk about the Northern Territory's context.

Obviously, I respect the words and discussion by the Member for Barkly, but the other role the Member for Barkly has is Minister for Health. Advocating for best practise and trusting our medical professionals, health practitioners and health workers is a part of the Member for Barkly's role. Therefore, it should enter into the debate and perspective, the evidence and the viewpoints of the medical professionals who this very clause goes to restrict, limit and hinder their ability—our medical practitioners, health workers, practitioners and everyone in the definitions. What the discussions and the scrutiny of this clause has led to, right now, it is not trusting of our medical professionals, health workers or health practitioners to do the job that they have sworn to do with all the codes of conduct, AHPRA requirements and allied health services—we very much thank

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everyone who works in Health for the work that they do, but this clause goes against trusting our health professionals, practitioners and medical experts to do the best possible job that they do.

We have heard the Australian Medical Association of the Northern Territory speak at length over multiple years, multiple inquiries, multiple committees and multiple reports that they will adhere to and uphold to the best of their abilities their job, their love, their passion to deliver the best possible medical health advice possible for Territorians. This does not take away from their sworn oaths to deliver those medical expert services in the Northern Territory.

Clause 16 does not provide medical practitioners, health workers et cetera with the ability or trust to continue in that work in the way that we would expect when it comes to administering—not even administering, but to have open medical discussions and transparent discussions with a patient about what voluntary assisted dying means, or the process of, by limiting the option in the very first place of providing this—something our medical professionals do every day—as a range of options available to someone, particularly when we know the very clear criteria and threshold of what a terminally ill Northern Territorian may experience or be going through.

While there are obviously some personal beliefs and debates on this and the preparedness to speak for and against—I absolutely respect that—the crux of clause 16, the wording of it currently, does not permit or respect our medical professionals to do the job they do for us every day. Not trusting our medical professionals goes down a very dangerous slope when politicians—someone said it earlier that someone would trust their doctor better than their politician—start to meddle in someone else's expertise and tell them what they can or cannot do when we're talking about delivering health services to the best of their ability here in the Northern Territory.

The way clause 16 stands as printed, I would hate for it to be the sealing of the deal and completely removing the ability of our medical professionals to provide the expertise and every option at their fingertips so that a patient-informed decision can be made. It removes that completely. I know there is some wording around it needing to be patient led, but I go back to the original example that I made.

The cancer patient walks through the door of a practice. They may not know that there are several different options available to them, and they may be looking at what this cancer means to them. Should they or should they not undertake cancer treatment that is available to them, or when things are really tough, painful and there is suffering—unfortunately, we have heard some very harrowing stories about the reality that a doctor cannot raise this option until the patient raises first.

We have spoken about if a patient does not speak English as a first language. What if a patient has other issues that have taken place and are not in the mindset to raise this with their medical health professional? It is a dangerous slope when politicians start to tell the medical profession what it can or cannot offer a patient.

I therefore do not support clause 16 as printed.

There are amendments afoot. The inability of the parliament, the people who are elected to represent the Northern Territory, to trust our medical professionals to deliver and administer the best possible advice, guidance and professional care goes against the intention of this Bill, which provides choice to Territorians.

Saying one thing and doing the opposite does not make sense to me when we are trying to create the most fit for purpose, best practice and most contemporary piece of legislation that Territorians expect from us.

Mr EDGINGTON: I trust all health professionals.

Ms UIBO: It does not sound like it.

Mr EDGINGTON: Let me finish. This is patient-led legislation. That is the way it has been designed and that is why I support the clause as it is.

Mr O'GALLAGHER: I have just been thinking about the trust of our medical professionals. We can trust them to have a conversation with the family when someone is on life support and they are having a very sensitive conversation about whether to take a person off life support. That is a personal decision the family has to be involved in, but we trust our medical professionals to have that very sensitive conversation. That is why I cannot understand why we would not trust our same medical professionals to have a sensitive and

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confidential conversation with patients about their options—not pushing one option, but the range of options. We are giving them information. It is still patient-led decision-making, and that is right.

The reason I support this legislation is it is voluntary assisted dying and it is patient led to make the choice. It is not the doctor making the choice; the doctor is only discussing a range of information. If we can trust them to talk to families about the options of turning life support on or off, which is a significant thing to do, I am sure I can trust them to have a good conversation with patients.

Madam SPEAKER: Is it the will of the room to move on to amendments shortly? Did you want to speak again?

Dr RAHMAN: I want to make a point before we move to the amendments because I want to speak to the amendments cleanly.

I make no secret of the fact that I thought the 2024 independent expert inquiry, which was auspiced by the former government, was sufficient basis for the CLP government to make a draft Bill. However, our government's stated position was that the information in that report, particularly in relation to appendix 9, which is about consultation out bush, was insufficient. The Members for Daly, Wanguri and Blain and the former Member for Nightcliff and I were tasked with finding out exhaustively what we could within a four-month period.

The Member for Barkly, with respect, has quoted a tiny piece of that information from appendix 9. We could be here until October sittings if I start going through the 440 submissions' worth of concerns about making sure we do this in a culturally safe way, people do not do things under duress, we protect people and that people who should not be saying something do not say something. I think it is fair enough to bring up key parts of the argument that support your personal feeling on this matter, but I do not think it is fair to suggest that the totality of the evidence in any way suggests that we are not trying to protect people from not being spoken to, out bush in particular, and being given the wrong information.

What has been exposed is that we are on the same side, essentially. I do not know whether that will result in anyone seeing the light of day on the logic of the argument, but the government Bill's fundamental policy priority is to ensure that patients cannot do something under duress. We have exposed 101 ways in which the matters can be raised where there are no proper controls over who can speak and what they can say.

It is as simple as this: if you want to protect patients and let it be patient led, you have to provide some parameters around who can say something and what they can say, not just say that nobody can say anything because that will not work. That is what we just figured out. It will not work as it stands at the moment. Any version of this is a better version at this point.

I am asking the Attorney-General to consider amendments that the government might consider making instead before we proceed to mine. My amendments have been circulated for weeks now or close to it. I am happy to speak to them, but this is a matter of conscience in this House. It is a government-led Bill. In the same spirit as we corrected an error this morning, I think this is a way to improve the Bill to make sure that only the people who know what they are talking about say anything because that is precisely what my version of this does, I think, in a pretty legal watertight way. If the government wants to adopt the language that I utilised or adapt some part of it. Any version of that I think is an improvement.

I am not sure how to proceed procedurally because I can see the Attorney-General is conferring to try to make decisions on this. In the interest of time and being reasonable and practical, it is, you are right, necessary for us to move on at some point to talking about amendments and all of the supporting arguments surrounding it. We can be here until October sittings talking about the 1,001 studies, saying that the gag clause does not work and minority positions on being careful about duress. We can do that until the cows come home, but the specific amendments that I put up are to try to ensure that we are protecting exactly the vulnerable terminally ill patients that the government is trying to protect and that we exposed clause 16 does not reasonably look like it will.

I am not sure how to proceed. I am happy to proceed; I can see the Attorney-General is conferring.

Madam SPEAKER: Could you take your seat for a minute? A critical question for the room: I am conscious that some people have been here since the beginning of Question Time. Do we need a five-minute break? We will come back in five minutes.

The Assembly suspended.

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Clause 16:

Madam SPEAKER: We resume consideration in detail on clause 16.

Ms UIBO: In regard to some of the information and questioning that has come to light today, do you intend to work closely with the Department of Health about ensuring that if there is any crossover in terms of the legislation and what needs to be implemented, that we will see any broader definitions or processes that expand the current clause 16, or is this something now that will be seen as a way to get around clause 16 with some of those perceived loopholes?

Ms BOOTHBY: NT Health will have its 18-month implementation review in which it will go through all of this, and then there is the three-year review.

Ms UIBO: I move amendment 2 in Amendment Schedule 70OPP (Ms Uibo) to replace clause 16.

I do not think I need to outline every reason, as we have already discussed it, but I do not believe that clause 16 is fit for purpose based on the recommendations provided by the government-dominated LCAC about the processes and the medical expertise. All tools should be available to our medical practitioners, health workers and health practitioners.

The wording in the amendment I propose speaks about the ability for health workers and medical practitioners to discuss voluntary assisted dying, the treatment options that are available and particularly the palliative care services that are available. Later I will propose a set of amendments specifically about palliative care.

Healthcare worker-initiated discussions should not penalised, which is why I propose this amendment to ensure that the process and opportunity to access information to be consulted about voluntary assisted dying is open to all Territorians who fit the criteria and threshold of having a terminal illness, and remember that is a very high threshold.

In terms of unprofessional conduct, that is specifically outlined in my amendment in subclause (4). Honestly, it was reflected in the discussion before—obviously I did not expect some of it—which has been quite useful and helpful in interrogating clause 16 specifically. We have safeguards and safety nets for our medical practitioners whom we trust every day to do their job professionally. I do not think introducing voluntary assisted dying should diminish what we already expect and experience every day from our medical practitioners and their expertise and advice. Evidence shows that medical professionals should always have the ability to provide the best and most relevant options for medical care for any patient. They should not be gagged. They should not be stopped or mistrusted to their job day-in and day-out because of the introduction of voluntary assisted dying, which we anticipate will be in the Territory very soon.

Dr RAHMAN: I think this is a step in the right direction at least. It provides greater protections than the current clause 16, but it does not provide broad enough protections in the manner that I am proposing. I think this will at least say something, that essentially everybody has pretty much accepted a medical practitioner is prohibited from being able to speak, but there is a range of ways that this can be frustrated as well.

I want to support some change to clause 16 for us to be able to ensure that genuinely patients are not ill advised. I am not entirely confident that this is broad enough to do that. The amendment that I have circulated instead, by contrast—I will speak to it separately if this amendment is defeated—is for all healthcare workers. That is where we basically found a real problem. This is not just about medical practitioners. This particular provisioning is set up so that only doctors can talk to people, provided they talk about treatment and palliative care options.

However, there is a critical part of that which is missing. They are not talking about outcomes of that palliative care or treatment options. That is the standard that was picked up in the Queensland legislation through this discussion and debate. It is not enough, in some ways, to just talk about the treatment options and the palliative care services available to the person, you need to be talking about the likely outcomes of that treatment and that palliative care. Otherwise, again, you leave it open to being basically half-baked.

The suggestion that a healthcare worker can only pass the buck to a medical practitioner again puts us in an awkward position where we do not really define the parameters by which they have to do that. It is not spelt out well enough to say, ‘If you are any number of the million people we have just thought of who interacts with our terminally ill patients in the Northern Territory, then what are the rules to guide you in terms of what you have to do to try to get this information across?’

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Again, this does half a job but not the full job. It is better, though, than what we have at the moment, which is just denialism. The current version of this is well-intentioned denialism. We would be the only jurisdiction in Australia that has gone backwards on VAD since 2017. Every state and territory has built on what happened in the last place and tried to pick up the baton and then adjust to the modern science and position from the medicos, in particular. We are the only ones that will be going 10 years back to the 2017 standard if we do not do something.

The question is whether or not the motion that has been provided by the Member for Arnhem is enough of something. Again, it leaves open some of the same basic problems that the current clause does.

I wish that the Attorney-General considers putting forward government amendments to tighten up these provisions. They could be more restrictive than what I or the Member for Arnhem are suggesting, but at the moment they do not cover the field. It will not be possible to uniformly gag people if the provisions are, in practice, materially unenforceable.

That is what we have exposed many ways over today without going into all of the data, the literature and whatever else. If we want to protect patients who are terminally ill, then we need to do something in clause 16.

I do not know whether it is procedurally possible to try to ask for this motion to be amended. For example, the word 'outcomes' is not included in the standard under clauses 16(1)(a) and 16(1)(b). I do not know whether the Member for Arnhem would be open to that or whether we should just vote on this as it stands and then return to it. Member for Arnhem …

Madam SPEAKER: It is your decision.

Dr RAHMAN: I was not sure if I was …

Madam SPEAKER: You can amend the amendment.

Dr RAHMAN: I can amend another person's motion?

Madam SPEAKER: Yes.

Dr RAHMAN: Or suggest an amendment to that motion?

Madam SPEAKER: Yes. You do not need to seek permission, you can do that if that is what you want.

Dr RAHMAN: My suggestion would be to incorporate, at a minimum, on clause 16(1)(a) and (b) where it says 'the treatment options available to the person' to insert after that 'and the likely outcomes of that treatment'.

Similarly, on (b) after 'the palliative care services available to the person' I would insert 'and the likely outcomes of that care and treatment', if that is acceptable.

Madam SPEAKER: Member for Fong Lim, you need to do it in writing.

Dr RAHMAN: Yes, that is what I thought.

Madam SPEAKER: Perhaps if that is what you want to do, take your seat, do that and we can allow some other members to speak and we can come back to you.

Dr RAHMAN: Yes, absolutely, Madam Speaker. That sounds reasonable.

J DAVIS: I speak to, in general, amending this clause so that the gag clause is removed. I understand there may be different versions in the amendments before us, but the general guts of them is that the gag clause is removed.

We have talked about that a lot. People spoke about it in their speeches on Tuesday. We have heard from doctors clearly that they believe the gag clause stands in the way of them being able to do their work and provide their health …

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Mr MALEY: A point of order, Madam Speaker! Standing Order 155; you cannot just talk about random stuff. We are talking about an amendment by the Leader of the Opposition. You have to be confined to the clause or the amendment. The Member for Johnston just said I am not talking about anything; I am just going to ramble.

Madam SPEAKER: No, she did not say that.

J DAVIS: I beg your pardon, Deputy Chief Minister. I am talking about the gag clause specifically. That is the clause we are talking about.

Madam SPEAKER: Member for Nelson, that is not how I heard it. I think the Member for Johnston is talking about the amendment that the Member for Arnhem has raised.

If we are going to get through the night, we have to be fairly clear and concise about what we are doing, everyone, throughout the evening, Some of us might have to catch a plane in the morning, but we might still be here.

Please continue, Member for Johnston.

J DAVIS: To be clear, I am addressing amendments proposed to clause 16 in relation to removing the gag clause.

Madam SPEAKER: That is how I understood it.

J DAVIS: I strongly support the removal of the gag clause. It is evidence based. We heard there is not evidence to show people just know about VAD. There is clear evidence from many research—the paper you just showed me; I cannot remember what it is, sorry. There is a lot of research that shows people who do not know about VAD cannot raise it. Therefore, they are prevented from making the choice, which is what this Bill is all about.

The State of VAD report from 2026 shows clearly that in Victoria, where there was a gag clause, only 4% of people accessed it, whereas in every other jurisdiction it was far higher, up to 73%. There is clear data showing that where doctors are not prevented from sharing this information with their patients, patients can make the choice, which is what this Bill is all about.

We have heard, I quoted it before and will not do it again, clearly from COTA its concerns about the gag clause and what that would mean for the huge number of people it represents. We have heard from the AMA that this goes directly against what it believes doctors should be doing.

I strongly support …

Mr EDGINGTON: A point of order, Madam Speaker! I thought we were dealing with the amendment that the Leader of the Opposition had put up. What I am hearing now is proposing a different amendment. Are we talking to the amendment the Leader of the Opposition has put forward or are we discussing additional amendments?

Madam SPEAKER: The Member for Johnston, from what I understand, is talking about the amendment. If she chooses, like the Member for Fong Lim is apparently choosing to do, to amend the amendment, she can do that at some other point. We are talking about the amendment brought forward by the Member for Arnhem.

J DAVIS: I support this amendment. I am interested in discussing other amendments that may come before the House in relation to this clause.

Mr CHARLS: I oppose this amendment. I will read out part of an email that a GP from my electorate sent me:

‘I am a GP who sees firsthand some of the abuse of systems and strain on our current health system. I am opposed to VAD in general. However, as it is likely to pass, I would like to see safeguards in place.’

This is particularly about clause 16 and the amendment to it which is being discussed. Why is this legislation is in front of us today? Is it because the people of the Northern Territory want it or is it that the professionals, doctors and all the others want it? I strongly believe, as the Member for Sanderson, that the people of the Northern Territory want this, and they are the ones who communicated with all the members of this parliament

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as constituents. I do not think there is an issue like they do not know about this voluntary assisted dying legislation.

I think that as many members of this Chamber discussed earlier, they are talking about the individual not being aware of this option. Many members of this Chamber wants this to be initiated by the doctor, but I am 100% sure, based on communication with members in my electorate, they are aware of this legislation and have the ability to raise what they want to their health professionals. That is exactly what I heard from a GP, and I spoke to many members of my constituents.

Again, many members said they may not be supporting the legislation, but at the same time they do not want to stand in front of something to be passed as well. I want to be very clear that I will be opposing these amendments.

Madam SPEAKER: Member for Fong Lim, is it your intention to amend the amendment?

Dr RAHMAN: No, Madam Speaker.

Madam SPEAKER: Is there any intention to amend the amendment? You mentioned you intended to amend the amendment.

A member: No.

Madam SPEAKER: Okay. Member for Nightcliff, you're speaking to the amendment from the Member for Arnhem?

Mr SMELT: Yes, Madam Speaker, speaking to the amendment from the Leader of the Opposition.

Madam SPEAKER: Correct.

Mr SMELT: Madam Speaker, I just want to make a couple of brief references in this point in the debate. I think it has been established across the Chamber a number of times already today, but the trust and relationship between patients and clinicians is absolutely paramount. That needs to be respected and protected, and I think what the Leader of the Opposition has proposed goes to that point exactly.

In addition, this amendment is also broadly consistent with the 2024 expert report, commissioned under the former Labor government. It is also consistent with the LCAC report, led by the Member for Fong Lim. On this basis, I think we should really consider what this amendment will provide.

In addition, as has been discussed previously, I am conscious that we are introducing a particular wording with the Bill as it stands that has actually been removed from number of other jurisdictions, including Victoria most recently. As we heard earlier, South Australia is also looking at potentially removing it as well, and I do not think it would be a good or wise decision by this parliament to introduce that outdated legislation here.

I also want to quote briefly—to give our doctors and clinicians a voice here—the President of the AMA NT, Dr John Zorbas. He noted recently, and I think he puts it very succinctly:

> *Patients rely on their doctors for complete, transparent information to provide informed consent. Legislating what a doctor can and cannot discuss when a patient is facing the end of their life is an unacceptable intrusion into clinical practice.*

I think we should all reflect on that. Ultimately, this amendment provides maximum care and transparency when clinicians can have those open discussions with their patients, and that is why I support this amendment.

Dr RAHMAN: Madam Speaker, just very briefly, having conferred with other people who seem to have concerns about this clause, the reason I do not seek to amend the motion on the table is to make sure my amendment is materially different still and, if this amendment is defeated, that there is still the option to discuss that in its totality. So it is not a personal slight or reflection on the amendment movement moved by the Member for Arnhem. I think that that is it is still an improvement on what is currently a problematic clause 16 embedded in the government Bill as it stands, but I just want to ensure that we do not end up killing two birds with one stone by accident. So I will seek to raise my own amendment and speak to it in its totality. I have nothing further to add on this particular amendment.

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Mr YOUNG: I spoke passionately about this part of the clause in my speech on Tuesday. have spoken to many people in my community about the gag clause and the concerns I had regarding cultural sensitivities. I believe that we need to come into this House with humility, openness and understanding. I met with Dr Linda Swan and Founding Director Andrew Denton from Go Gentle. We had an honest and open conversation about what a gag clause may look like.

I am confident that removing the gag clause will not impede Aboriginal people in remote communities. I think it opens up a discussion that is carefully framed. We can put parameters around that. I believe it improves the safety net by ensuring that medical experts have those conversations. If we have this gag clause in place, it could become quite dangerous, if the wrong people are having conversations with people who may speak English as a second language. English may not be their first language of people from remote communities.

We went out as a committee. It was tough because we are not experts in this field. I think we did a good job, and we were sensitive to the language we used. However, we are not trained practitioners or doctors. That conversation was open, and the right information was given to people from remote communities. It was clear that it would be a person's choice to have access to voluntary assisted dying. Each family has their cultural beliefs when it comes to the end of life, but people are open to talking about it. When we have doctors speaking about it, that is the safest way it can be done.

I will be voting for this amendment. I hope other members who were thinking of voting for the gag clause can open their minds and look at the safety nets it will put in place. You entrusted us, as a committee; to go out to remote communities to have those difficult conversations, so why can you not entrust the doctors to have those conversations if needed and someone is terminally ill? Look at the evidence around Australia. The Minister for Health mentioned earlier that we are not South Australia, WA or Queensland. However, there are similarities with our remote communities where English is not people's first language. Look at the APY lands, the Kimberley and north Queensland. It shows that without this gag clause, there have been no issues in remote communities.

The issue I have with this gag clause is that many people who are terminally ill and eligible to access voluntary assisted dying are unlikely to bring it up with their doctor. Dr Swan spoke to me about that. You go to the doctor to get advice. It is not you going as a patient to say, 'I want this, that and the other'; it is because you generally do not know your options. When I go to a doctor it is to get advice from that doctor to understand my options, depending on the medical issue I have. This is no different. We should trust our doctors to have those sensitive conversations if they are needed. They will be making the judgement on that. They will be well trained. It will not be a first-year doctor going straight out to a remote community, if that is what people are concerned about. It will be experienced doctors who have been in the field for a long time. Doctors give us advice so that we can make an informed decision on that.

Again, I remind those members who are thinking of voting against the amendment that your government entrusted us to have those difficult conversations with remote communities. We had no issues, but we met and we were clear in what information we were giving and were honest in the information and what we were there to do.

As I said earlier, you can come with this with a bit of humility and see that this is actually safer for people to access. I will be supporting the amendments.

Mr YAN: Before the Member for Mulka retired he sent an email to all of us. I support what Yingiya said in his email because I understand exactly where he is coming from. I will read Yingiya's email he sent to all of us:

> *Dear Members*
>
> *I also want members to consider that the Northern Territory is a very different place to other places in Australia because many people live in remote Aboriginal communities and we have diverse cultural perspectives.*

I understand this from my electorate.

> *Clause 16 will provide significant cultural safety for Yolngu communities because if VAD is introduced to our communities and initiated through visiting nurses and doctors, there is a possibility that many people will fear their clinics and blame the clinics for early deaths.*

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That is not part of our culture and many people are afraid of talking about it. Most visiting nurses and doctors do not have the language skills or cross-cultural training to understand our perspective, and sometimes unintentionally do long-lasting damage.

If this Bill is going to pass, as the government has already stated, the remote communities must also be considered so we do not see side effects such as avoidance of clinics and increased confusion and health problems when we are already seeing so many of our loved ones die.

I support Yingiya's comments. I said this morning on radio that there needs to be that clear delineation, particularly in remote areas where possibly communication between doctors and people out in the bush—people in the bush see that communication from a doctor as what they should do. That is important in this discussion. I wanted to put Yingiya's comments on records because they are quite wise comments that are quite right.

I support what he says, and support clause 16 as it currently stands. I do not support the amended motion.

Madam SPEAKER: Member for Johnston, are you speaking to the amendment again?

J DAVIS: The amendment and the point just raised.

Madam SPEAKER: Please continue.

J DAVIS: Thank you for sharing the words from the former Member for Mulka. Exactly as you said, there are serious concerns we need to take on board when we are looking at this Bill. That is exactly why we need to make sure that this clause is strengthened. At the moment, it creates the possibility for causing the kind of harm that Yingiya has described. I support the amendments.

Mr YOUNG: Going back to this amendment, that email that the Member for Mulka sent out was the reason that I thought it through carefully. Initially, as I started before, I thought, 'This is something that we need to consider in remote communities'.

I completely respect the point from the Member for Mulka, and understand his point. As I said on my speech on Tuesday, it is a difficult decision that we are all wrestling with—in particular I am wrestling with—because I believe in removing the gag, but then I can see the points that the minister just raised in regard to that cultural safety net by having this gag clause.

After meeting and speaking to my colleagues and the Leader of the Opposition, your colleagues and the Member for Fong Lim, I also met with Go Gentle Australia. It is clear to me that we need to have these discussions by medical experts if the patient has become terminally ill. That needs to be done in a very sensitive way if the options are there. But also if we go back to the regulations, they can be tightened as well. It is very unlikely that it will be spoken in remote communities—is what I am getting at—because the doctors trained in voluntary assisted dying are more likely to be in an urban setting. Then if they are to have those discussions in remote communities they will obviously be trained and culturally sensitive to what has just been read out from the Member for Mulka.

I have complete confidence that we need to amend this part of the clause to give a greater cultural safety net to ensure there is no misinterpretation of what voluntary assisted dying is because anyone can go and speak to someone about it; no-one is stopping anyone from having those conversations. As I have said, we have gone out and had those conversations. We are not medical experts in the field when it comes to voluntary assisted dying. We did think deeply about how we would go out to remote communities given the short timeframe we had.

Those conversations were fine because we were honest with what was being proposed by the government and what voluntary assisted dying is. Overwhelmingly, people from remote communities recognised it was a choice at the end of the day. There were some family members who said that they would not do it as a family unit, and that is the point of this Bill; that is the principle of this Bill is that it is a choice, it is a person's choice. The stats show that.

When we saw the gag order in Victoria—and people who were eligible to access voluntary assisted dying most of them did not know about it; only 4% of people who were eligible could access it, but when the options were given it showed that people were able to go back and think about it. We must remember there is a very strict set of rules to get to the point of voluntary assisted dying. It is not that first conversation, it is the initial

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conversations that lead after that. It is not an easy process to get there. I would hope again that you come at this with humility.

It is okay to change your mind on things and go and have those discussions; that is completely fine and is why we are elected so that we can be open minded about that and change our positions on things; that is the role of our job as members of parliament as politicians, to be informed and to come in here. It is okay to get things wrong. Politics gets a bit heated at times but when it comes to voluntary assisted dying, this is too important for Territorians who want to access voluntary assisted dying to have those direct conversations with their doctors knowing the doctor is doing it in the right way and the most sensitive way because it can be hard for a patient, particularly someone who is very ill, terminally ill who has come to their doctor and bring up voluntary assisted dying.

It could be interpreted differently from the doctor, how that patient brings it up. It is very hard to talk about voluntary assisted dying. It could be interpreted from the patient to the doctor that it was not discussed, then they both leave the room and that patient who was willing and wanting to have that conversation with the doctor is then going to feel completely disempowered and may feel they are not able to have that conversation with another doctor if we keep this clause as is. That is why I am asking that we amend it.

Mr O'GALLAGHER: Can I just say in regard to the amendments—I will go back to my original short speech on Tuesday. As an MLA I am here to represent my electorate and the view of my electorate; that is what has been guiding me. My electorate told me they want VAD legislation passed, and I gave a commitment on Tuesday that regardless of the form, I will pass this Bill in the final version—have no doubt about that.

I also mentioned on Tuesday that I had a lot of feedback from my electorate asking to remove the gag clause. Just as I responded to people's wish to bring in VAD legislation, I have to listen to that as well. They do not understand why this legislation is coming down like a sledgehammer on a rusty nail, or whatever you want to call it. It just seems an overreach. I know the intention is good. I am not against the intention. I just think the means is probably the wrong way.

Having said that, I will support any amendment that improves this clause. Why wouldn't I do that? If another amendment comes back and does further improvements, I will support that. I will support the amendments, but, if they are all defeated, I will not support this particular clause. I will support the Bill as a whole.

Madam SPEAKER: The question is that the amendment be agreed to.

The Assembly divided:

Ayes 8	Noes 15
Mr Brown	Ms Boothby
J Davis	Mr Burgoyne
Mr O'Gallagher	Ms Cahill
Dr Rahman	Mrs Carlson
Mr Smelt	Mr Charls
Ms Uibo	Mr Edgington
Mr Young	Mrs Finocchiaro
Mrs Zio	Mrs Hersey
	Mr Howe
	Mr Kerle
	Mrs Lambley
	Mr Mackay
	Mr Maley
	Mr Patel
	Mr Yan

Amendment not agreed to.

Dr RAHMAN: I would like to speak to my amendment in totality in respect of clause 16. Is that procedurally acceptable?

Ms UIBO: You just have to move your amendment.

Dr RAHMAN: Sorry, I cannot find a script.

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Madam SPEAKER: Just talk to your amendment if that is what your intention is.

Dr RAHMAN: My intention is to speak.

Madam SPEAKER: Read the amendment.

Dr RAHMAN: This is the thing. I just want to clear this up, Madam Speaker. Rather than speaking to each individual line item amendment, I was hoping to speak to the totality because I am seeking to replace that in its entirety. Must I speak to each line item?

Madam SPEAKER: Do you seek leave to take the full amendments together?

Dr RAHMAN: Correct. It is just in the interests of efficiency as much as anything else.

I seek leave to speak to the totality of your amendments, pursuant to clause 16.

Leave granted.

Dr RAHMAN: The intention of this clause is not immediately as it seems. It is not just to allow people to speak; it is to protect people who do not want to speak. That is why I think the Member for Daly and other members have got behind this, because they see that the current clause 16 does not afford protections and allows people to opt out when they do not want to speak. These amendments ensure that only somebody who knows what they are talking about is in a position to say something.

Unlike the Member for Arnhem's amendment that was just defeated, it is broader and applies to all healthcare workers. We have just established that a range of healthcare workers interact with our terminally ill patients. It is not clear how the existing clause 16 will prevent anyone from speaking or what the enforceable consequences would be if people were to speak out of turn and ill-advisedly.

This is the best, heartfelt version of this, utilising whatever legal wisdom I have and whatever counsel I have received to try to correct that—to do exactly what the government's stated policy position is; to ensure that it is led by and protects patients. That is the thing; I am trying to protect terminally ill patients against duress and, at the same time, ensure that anybody who does not want to speak does not have to speak by simply saying, 'I cannot satisfy the conditions to speak'.

Line by line, it is about changing from 'the healthcare worker must not initiate a discussion' to 'a healthcare worker may'. That is a procedural clarification.

Clause 16(1) is about saying 'a healthcare worker may' rather than 'a healthcare worker must' not say anything. I have tried to respect the legislation exactly as it is and make as few changes as possible so as to not completely rewrite the thing, as happened in the preceding amendment.

Then proposed sections 16(1A) and (1B) are critical. Proposed section 16(1A), first of all, says that despite subsection (1) saying that a person can raise something that will materially, in substance, suggest VAD or initiate a discussion, they cannot do that unless they believe, on reasonable grounds, that the person satisfies all the eligibility criteria. That is much broader than anyone else is suggesting.

Your average healthcare worker will probably not be able to satisfy that. An ALO or patient care assistant who thinks, 'This is a poor sick person. Maybe I could suggest something', cannot just willy-nilly shoot from the hip. They can only say something if they can satisfy all the eligibility criteria under clause 19, which includes that the person is a citizen, a permanent resident et cetera. There is an exhaustive list of conditions in this Bill at the moment, even before we consider any possible amendments to the clause 19 eligibility criteria.

First things first, people can only talk about VAD with somebody if they are a healthcare worker and are sure, on a reasonable basis, that the person is eligible for VAD. If they are not eligible, do not say anything and you are not entitled to say anything. You can just say, 'I don't know. This is not for me to say.'

The second part of this is that despite subsection (1), the healthcare worker must not do a thing mentioned in subsection (1), like talk about this or suggest that, unless the worker at the same time informs the person, meaning the terminally ill patient who is eligible under section 19 of two things—one, the treatment options available to them and the likely outcomes, which is again, much more specific than what was being suggested in the preceding amendment. You cannot just be saying, 'You should be thinking about this novel treatment'

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unless you know it will work or not. Again, this narrows the field considerably. Some social worker, Aboriginal liaison officer or patient care assistant will not necessarily say, 'Hey, you should think about VAD, and maybe you should try this homeopathic treatment'. The point is, unless you can see what the treatment is and what its likely outcome is, do not say anything.

The final part of it subsequent to that is the same provision with regards to palliative care. Palliative care, unless you can advise, 'This is where your palliative care treatment options are, and this is what the likely outcome of that would be, do not say anything'.

This version of clause 16, I believe in my heart of hearts, in my guts, does what everyone in this House wants. I swear to you, I believe that this construction of wording does what the Assembly actually wants—the people who want to get rid of a gag clause in principle, the people who want to only have a gag clause if the right people speak, the people who want to ensure that things cannot be done under duress to a patient and the Attorney-General's policy position on it being patient led, not causing harm. This ticks all the boxes in my opinion.

The final part of it, 1(c), is introducing that a healthcare worker may only do a thing mentioned in subsection (1) in accordance with the requirements, if any, prescribed by regulation. Again, it is the same legal standard of later on we know things will come up in implementation that are super important for us to get right in the Territory because we have geography and language to overcome and a million other things that are difficult about our health system compared with any other part of the country. You always need, in my opinion, as a matter of good legal practice, that you will do anything still prescribed by regulation. Unless you are certain, that you can cover the field in the legislation, you should be putting that in there. Yes, it could mean you could make it more restrictive. Yes, you could make it more expensive. But really those regulations will not be written by anyone in this House. They will be done by people in the Health department, and that is how it should be, because they are the ones who will have to deal with this practically.

The final part of it is simply on Part 3—the final part of that amendment is just a tidy-up. Previously it was subsection (1), and now it just says 'this section'. That is just a cosmetic tidy-up.

The important part I want to point out about 1(b) which I just discussed now was that it is not my kooky clever idea; that comes from the QLD legislation. That is where we took that from because they had an exhaustive debate about this, about who should say something and who should keep their mouth shut. The point was they came up with this construction and this combination of words that you needed to advise about care, all options and the outcomes of that, and palliative care, all options and the likely outcome of that. This is the final version of what I think is the best possible construction of clause 16 to allow us to not just let people speak, but only let the people who should speak, speak to a terminally ill person to give them the information that they need, and everybody else should butt out, stay out or opt out, as the case may be. This is the best possible version of providing people with freedom and choice and the best-practice standard in clinical care, allowing our medical professionals to say if they are on top of this and feel they can, 'VAD may be an option for you', alongside everything else that I just went through.

Do not think that it will just be somebody shooting from the hip who will be able to say anything. This is legislating to fill a vacuum in our legislation. What we have discovered is the existing clause 16 basically is ostensibly silent, whereas by providing details we are actually making it stronger. That is my starting gambit.

Mrs ZIO: Madam Speaker, I just wanted to touch base on this one. People know that I would like the gag clause removed from this part of the legislation. People in the electorate of Fannie Bay have spoken to me directly about this clause. They want it gone. People from every other electorate have also contacted me and said they want it gone. So every member in this room has a large number of people in their electorate who are fighting for this gag clause to be removed from the legislation.

It is our job as members to listen to the people who live in our electorate, not make decisions based on what we want, and to make decisions based on what they are asking us to do. A lot of people in the Northern Territory are asking for this, so I would like to speak directly with members who are not yet sold on or who are uncomfortable with amending clause 16 as per the Member for Fong Lim's amendments, because I understand their concern behind this provision.

Nobody in this Chamber wants a vulnerable person to be sitting in front of a doctor and feeling like voluntary assisted dying is being suggested because they are old, sick, disabled or too expensive to care for or are somehow a burden. Nobody in the Chamber wants that. If a health practitioner pressures, coerces or improperly influences a patient towards voluntary assisted dying, we should come down on that conduct hard.

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But that is not what we are debating here today. We are debating whether a properly trained health professional should be legally prohibited from even initiating a conversation about a lawful end-of-life option. I ask members to think very carefully about the consequences of that.

We are about to pass legislation saying voluntary assisted dying is a lawful medical option for eligible Territorians. If we do not amend this clause, we will tell doctors that they cannot tell their patients about it unless the patient somehow knows the right question to ask first. How can that possibly be informed choice? A patient cannot make an informed decision about an option they do not know exists.

This matters enormously in the Northern Territory. Think about the patient with limited health literacy. Think about someone from a remote community. Think about someone for whom English is not their first language. Think about an elderly Territorian that has never heard the words 'voluntary assisted dying'. Think about someone sitting across from their doctor saying, 'Doctor, I cannot do this anymore. I can't keep living like this. What are my options?' Are we seriously legislating that a doctor can discuss pain relief, palliative care, treatment options and every other lawful form of end-of-life care but must deliberately leave out one lawful option from the conversation unless a patient happens to know the magic words they need to say first?

That is not a safeguard; it is withholding information. And worse, if we leave clause 16 as it is, we are essentially creating two classes of patients: those who are educated enough, informed enough and well connected enough to know that VAD exists and know exactly how to ask for it; and everybody else. That is particularly troubling in the Northern Territory, where geography, language and health literacy can already create barriers to accessing healthcare.

If we believe in patient-centred care, surely the patient is entitled to understand all of their lawful options. If we believed in informed consent, surely we must allow people to be informed. And if our concern is coercion, let's regulate coercion, prohibit pressure, require appropriate training and enforce professional standards and ensure oversight. But let's make absolutely certain that no practitioner can encourage a vulnerable person towards a decision that they do not want.

Do not confuse information with coercion; we have heard that a couple of times in the Chamber today. Telling someone an option exists is not telling them to take that option. Explaining voluntary assisted dying is not recommending voluntary assisted dying. Having a compassionate conversation is not encouraging somebody to die.

I ask all members who remain opposed to this amendment one simple question: are you saying that providing someone with lawful medical options is dangerous?

I do not want doctors encouraging people to die. I want doctors talking honestly with their patients about how they can live, how their suffering can be treated, what palliative care can be offered and, where clinically appropriate, what lawful choices are available at their end of life.

There is an uncomfortable contradiction if we leave clause 16 in place. We would be saying that we trust doctors to assess whether somebody is dying but we do not trust them to have a conversation. I cannot reconcile those two positions.

Ultimately, this comes down to the person sitting in that consultation room—not us, politics or ideology. It comes down to the patient. If they are making decisions about their end of life, they deserve all the information, not just the information parliament allows their doctor to mention first.

I say to members who are undecided, or concerned about removing clause 16, we can always strengthen safeguards against coercion, but do not turn silence into a safeguard. Silence does not protect an informed choice; it prevents one. I ask members to support the Member for Fong Lim's amendment.

Mr SMELT: I support this amendment from the Member for Fong Lim.

Similar to other speakers, the overwhelming feedback I have received from the people of Nightcliff is that they want this so-called gag clause removed. It is clear that everyone respects and wants proper safeguards, but that has to come with the right information. This is a blunt and outdated tool in order to achieve that goal.

As the Member for Fong Lim discussed, this is based on ACT and Queensland legislation. Those jurisdictions have been through this debate and they have this in action. We can learn from those examples.

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It also makes clear that if you do not know what you are talking about, you cannot initiate a discussion. That is critical. This is an important safeguard that should not be discounted; it comes as a package. There is both the requirement and the right for the clinician to initiate and have that conversation, but there is also the responsibility for that clinician to have done the training to know what they are talking about. It really is a package deal; you need both.

On that basis, I support the amendment and encourage other members to support it.

Mr YOUNG: This is a good amendment from the Member for Fong Lim. I agree with what the Member for Fannie Bay said.

This is a strong amendment, particularly regarding who is eligible in proposed section 16(1A) under the actual eligibility criteria in proposed section 19. Proposed section 16(1B) strengthens this in terms of, firstly, you have to know your treatment options; and, secondly, you need to know the palliative care options before you can even speak about voluntary assisted dying.

What got me over the line is that includes anything prescribed by regulation, within which we can ensure it is culturally safe. If there are clinics that may not want people to speak about it, it could be prescribed when the department does that level of work. This is a strong set of amendments. I think it really strengthens the Bill.

I do not want to go through my spiel from earlier, but doctors and health workers who have been trained to speak about voluntary assisted dying are best placed to do that. They will be culturally sensitive in having those discussions. They will be sensitive to anybody who comes to the doctor to start having those discussions.

It is a good set of amendments. I hope we can support this change.

This gag clause is dangerous. People may not know about it. People may not know how to approach their doctor if the gag clause is still in place. We should be able, if someone is clearly eligible, to lay it out clearly with the treatment and palliative care options. The doctors will know how to have those sensitive conversations, and I have full confidence in them able to do that.

Ms UIBO: I support the amendments brought forward by the Member for Fong Lim of a similar vein to ensure that we have the best fit-for-purpose legislation possible; that we show and respect that our medical practitioners and health workers are doing the absolute best possible job—that they already do, but under the introduction of VAD in the Northern Territory which we are all anticipating—that they will not be limited or disempowered to do that job and will continue to do that job to the best of their ability.

Of a similar vein as well, the Member for Fong Lim has raised specific points about his wording, which I am happy to support. I know you have done a lot of work in this space, but I think as the Member for Daly so eloquently put, this piece of legislation has shown that people not just in our community and organisations outside of this Chamber, but within the Chamber have evolved and matured around the information, experiences, conversation, interactions and engagement they have had—particularly within the last few hours, day, weeks, months and years leading to where we are at today.

I think it shows an extremely mature approach for anyone who has thought of a position, listened to and engaged with and perhaps decided to change their position in order to create again the best possible legislation for us to vote on today when it comes to the finality of the Bill before us. In terms of not putting the Territory backwards, I will reiterate the same points I made earlier today. We are in the unfortunate position of being the last jurisdiction in Australia to have the voluntary assisted dying rights that every other Australian has access to.

However, we do not need to create a backfoot or learn from the mistakes of other jurisdictions when we are creating our legislation for Territorians because the Territory is unique. Many people in this place have already spoken about all the reasons why, and we have that opportunity with all 24 members of the Northern Territory Legislative Assembly to ensure we do not put ourselves on the back foot. We want to put Territorians first and make sure we are on the front foot with legislation. Any positioning around the support for this amendment would show that maturity and that we are all listening and absorbing the many sentiments and perspectives and the many conversations and dialogue across the community.

I support the amendment clause 16. I am disappointed my amendment did not get up, but I have faith with the wording proposed for this clause by the Member for Fong Lim. There may be a stronger opportunity to

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see this amendment to clause 16 be successful and to show Territorians we are doing our job to ensure we have the best possible legislation to vote on this evening, whenever that may be.

I also want to speak to some contributions that were provided in the Chamber this evening, particularly around reasons for or against. I want to focus on what the Member for Namatjira spoke about when he read out the email from the former and outgoing Member for Mulka, Yingiya Guyula. The Member for Namatjira agreed and that formed some of his focal points of why he would not support any changes to clause 16.

I would only hope that the Member for Namatjira would also apply that same sentiment—could have in the last two years—to what the Member for Mulka raised time and time again in other legislation and other parts calling for community engagement, in other priorities Territorians have raised—begged and pleaded, in some points—for Territorians' voices to be heard so that changes could be made to legislation brought before the House, but ignored expert advice, community sentiment and the calls and pleas in regard to changes to Northern Territory laws.

It is disingenuous for a member of this parliament to quote a former member, an outgoing member of the parliament, and say, 'Yes, this is what I believe and this is how I support it, and what great points', when they did not do that anytime in the two years before.

I make that point, and I support the Member for Fong Lim with the wording of clause 16 and moving it en bloc. I can hear the Member for Barkly; hopefully he will contribute again rather than trying to disrespectfully interrupt the comments that I am making.

Mr EDGINGTON: Make them relevant.

Madam SPEAKER: Cease the interjections. Please continue, Opposition Leader.

Ms UIBO: I did not think what other members of parliament said was irrelevant. I think the work that has been poured into what is being debated today, particularly with consideration in detail, is extremely relevant and important, and I hope we see all members vote with their conscience. I think that shows maturity and sensibility. It shows that as members of parliament we are all doing our job. I cannot believe that position on health—particularly by the Minister for Health—would show distrust for those who work in the health profession.

I think that the changes to clause 16—mine were defeated, unfortunately. I hope and very much believe that the amendments proposed by the Member for Fong Lim should be accepted. I hope they are adopted to ensure that all of the work up until today is not wasted and that we see changes to make the Northern Territory be at the forefront, progressive, suitable, fit for purpose and contemporary. I hope that we do not do a half-hearted exercise, leaving clause 16 as it stands printed. Clause 16 should be amended, and I support the Member for Fong Lim's amendments.

Mr O'GALLAGHER: Madam Speaker, I support the amendment. Any improvement on what we have is better than none. I really do not see this clause being able to be enforced anyway, so I see it as redundant in some ways.

Having said that, I trust our health professionals, our doctors and that relationship. All we are trying to do is let doctors give the full range of options to their patients. Yes, it has to be the patient's decision, always, and it is not about doctors marketing one over the other.

I can also imagine if you asked a doctor, 'What should I do?' and he says, 'You can start here and go there', that discussion with the doctor may well be, 'Look, don't even think about that yet. We have much better pain management techniques that you may not have fully considered, and we have good palliative care options too'. They will not be trying to jump people into VAD, but they will give the spectrum of options. It has to be a patient decision, so when we talk about patient-led things, the patients will make the decision. All the doctor is doing is giving them a firm base of information so that they can make an informed decision, and I welcome them. I would love, and hope, people say, 'Once I've spoken to the doctor, maybe I have better options to look at rather than going to VAD', and that will be a great outcome if that happens.

I have full trust in our health professionals, and I still have concerns that this clause is unenforceable, so I am not too sure why we are pursuing it.

J DAVIS: Since we first heard the details of this Bill, I was clear, on the basis of hearing overwhelmingly from my constituents and people across the Territory, that people did not want this clause. I was public in saying

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that I would be moving amendments on this clause. I saw other amendments that I believe covered it even better and that I would support them, and that is what I am doing today. People overwhelmingly want this across the Territory, and that is what we are here to do.

We have an opportunity now. We have heard all the evidence, and I will not re-prosecute that. We have an opportunity to have the safest and best Bill that protects people rights and enables people to get the information they need to make a choice in a way that protects the issues that people are worried about here. I strongly support this. As we have heard from other people, I encourage all people across the House to make this Bill represent what the Territory wants.

Mr YOUNG: I did not mention one part to my previous contribution. I want to add in about proposed section (1C):

'The health care worker may only do a thing mentioned in subsection (1) in accordance with the requirements, if any, prescribed by regulation.'

The government made it clear that if this Bill was to pass, it will not come into effect for 18 months. People will not have access for a minimum of 18 months. As a government you have 18 months to get the regulation settings right within VAD being rolled out. This is where the government needs to ensure that these safeguards are in place for all communities across the Northern Territory.

Mrs ZIO: I want to say one last thing to impress on people the position from a majority people across the Northern Territory who are invested in voluntary assisted dying and their desire to have this clause removed from the Bill or changed, altered or amended, as we are proposing.

I cannot justify implementing legislation that professionals, doctors and people who are mostly in charge cannot discuss with their patients as an option. I want members of this Assembly to think about how we are giving people a lawful option, but 'zip your mouth; you cannot talk about it, unless someone comes and talks to you first.' I cannot see the sense in that decision. Members of this Assembly, please think about that. Think about the people who have come and spoken to you about this. Think about the publicity that removing the gag laws has struck across the Northern Territory.

Sue Shearer from COTA NT—people who talk to people who are interested in this law and are interested in getting this clause changed. I impress on people to have a think; it is a conscience vote. Nobody will get in trouble if you are voting one way or the other. Have a think about what your electorate wants, and if that reconciles with you, please vote in favour of amending as per the Member for Fong Lim.

The Assembly divided:

Ayes 8	Noes 15
Mr Brown	Ms Boothby
J Davis	Mr Burgoyne
Mr O'Gallagher	Ms Cahill
Dr Rahman	Mrs Carlson
Mr Smelt	Mr Charls
Ms Uibo	Mr Edgington
Mr Young	Mrs Finocchiaro
Mrs Zio	Mrs Hersey
	Mr Howe
	Mr Kerle
	Mrs Lambley
	Mr Mackay
	Mr Maley
	Mr Patel
	Mr Yan

Amendment not agreed to.

The question is that clause 16 is agreed to.

The Assembly divided:

Ayes 14	Noes 9

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Ms Boothby	Mr Brown
Mr Burgoyne	J Davis
Ms Cahill	Mr Kerle
Mrs Carlson	Mr O'Gallagher
Mr Charls	Dr Rahman
Mr Edgington	Mr Smelt
Mrs Finocchiaro	Ms Uibo
Mrs Hersey	Mr Young
Mr Howe	Mrs Zio
Mrs Lambley	
Mr Mackay	
Mr Maley	
Mr Patel	
Mr Yan	

Clause 16 agreed to.

Clauses 17 and 18, by leave, taken together and agreed to.

Clause 19:

Ms UIBO: I move amendment 3 in Amendment Schedule 70OPP (Ms Uibo) to clause 19(1)(d)(ii) to remove the limitation of the 12-month prognosis. This has come up multiple times across the communities. I think everyone is aware of this. It has also been requested that the reasons for omitting this limitation—which is the current clause 19—is we have seen evidence from other jurisdictions that shows arbitrary time frames can exclude many dying and suffering people simply on the basis of an unreliable prediction. We saw the LCAC report for the Northern Territory Legislative Assembly, which recommended not including a time frame for death because medical practitioners can have difficulty predicting a person's remaining life outside a narrow period of days or weeks. The LCAC report process also considered that there were already sufficient safeguards to the Bill to ensure that a person's condition was terminal, and that people with neurological, respiratory and chronic organ diseases do not always follow a linear decline unfortunately. We heard some harrowing stories over the last few months and years of this process to get us to this point.

The Northern Territory has an opportunity to lead from behind—we find ourselves again as the last jurisdiction in the country—to be able to ensure that a Territorian who is suffering from a terminal illness has the ability to go through the journey and process of voluntary assisted dying without having the 12-month prognosis limitation.

Some of the examples that people have given were completely extreme and not helpful in a discussion as sensitive as this. For example, some of the counter examples and experiences speak about people who are suffering a terminal illness who may have a prognosis or a prediction of life ending that may be 14 months, 13 months or 15 months.

To disempower that individual accessing the process of going through the journey of voluntary assisted dying—should they have the choice to do so—goes against what we are trying to do overall with this Bill before the House today; that is, provide Territorians with that individual and voluntary choice to access VAD services and care because of that restrictive 12-month period.

I reiterate that the government-dominated LCAC committee report recommended not including a time frame to death because of the reasons that we outlined. We have seen and heard that other members of the House have a similar view.

It would show goodwill and good spirit to listen to our community overall and ensure that the Territory is not on the back foot. It is pretty to omit the time frame to allow our expertise and our health workers to do what they do best but, more importantly, be able to allow that patient who may be suffering in pain the opportunity to be supported as best as possible without a time limit attached to their diagnosis.

Therefore, I commend the amendment.

J DAVIS: I also support this amendment for similar reasons that we have talked about before. This is something that the vast majority of my constituents and people from across the Territory have said to me. 'It is important that we get this Bill right'. This is one of the things that we need to make sure that we get right.

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I understand why a time frame feels to some people like a safeguard. It sounds like a clear objective line; you either meet it or you do not. That sense of clarity is actually an illusion. We heard that from doctors, people who work with people who are terminally ill, and from people who are terminally ill.

Having a 12-month prognosis period does not meet the intention of this bill. It does not enable people who meet all the other criteria to actually prevent intolerable suffering and make the choice for VAD. There are lots of examples of this, we heard some of them in speeches on Tuesday, so I won't go through them.

I will talk about one person briefly: Gavin Perry, who I have had a lot of contact with. He spoke to me very explicitly, as other people have, saying 'Please remove this from the Bill. This will have an absolute fundamental effect on my life. I know if this Bill passes with that, I may not be able to access it. It is incredibly important to me and has a huge impact on my life.'

Eligibility should turn on suffering, not on a number, that no clinician can confidently give their patients.

I strongly support this amendment.

Mrs ZIO: I have the same amendment as the Leader of the Opposition, to remove clause 19(1)(d)(ii) from this bill.

The effect of this amendment is pretty straightforward. It removes the requirement that a person's disease, illness or medical condition must be expected to cease death within 12 months. I want to be really clear about what this amendment does and what it does not do.

It does not remove any requirement that the person have a disease, illness or medical condition that is advanced and progressive. It does not remove the requirement that condition be…

Mr MALEY: A point of order, Madam Speaker!

I am just confused. Does the Member for Fannie Bay basics thinks she is talking about her own amendment.

Mrs ZIO: No. I am talking about hers.

Ms UIBO: It is the exact same amendment.

Madam SPEAKER: Please continue, Member for Fannie Bay.

Mrs ZIO: It does not remove the requirement that the condition be expected to cause the person's death, and it does not remove the requirement that condition be causing suffering that the person considers to be intolerable. It does not remove the safeguards around adulthood, decision-making capacity, voluntariness, coercion, medical assessment and any other eligibility requirements contained within this Bill. It removes one thing, an arbitrary 12-month clock.

My concern is that a prognosis is not a precise science. Medicine can tell us an enormous amount about the likely progression of disease, but it cannot always tell us with certainty whether a person has 10, 12, 14 months or considerably longer to live. A prognosis is not a stopwatch, and disease does not read legislation. This becomes particularly important for people living with progressive neurological and degenerative diseases or conditions.

As I spoke about in the second reading debate, Sam Turner's experience with FSHD demonstrates this problem. Some terminal illnesses may eventually provide doctors with relatively predictable prognosis. Others do not.

A person can experience years of progressive deterioration, increasing disability and suffering without reaching a point where a doctor can confidently say that the death will occur within 12 months. That creates, in my view, unfair decisions and unfair distinction.

Under the current Bill, as it is drafted, we could have a person whose condition is advanced, progressive and will ultimately cause their death. Their suffering is intolerable, and they have decision-making capacity. They might be fully informed, acting voluntarily and without coercion. They satisfy all the other safeguards in the legislation, but we would still be required to say to them, 'Because your doctor cannot legitimately say you will die within the next 12 months, you cannot have access to this service'.

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I struggle to see the compassion or logic in that distinction. Importantly, removing paragraph (ii) does not make voluntary assisted dying available simply because somebody is living with disability, chronic illness, or suffering. That is not what this amendment does. The condition must still be advanced. It must still be progressive, and it must still be expected to cause death.

All the other safeguards and assessment requirements still continue to apply. This is not about removing any safeguards; it is about removing an arbitrary time frame from an otherwise rigorous eligibility test.

Parliament should establish really strong safeguards. We should protect vulnerable people and require informed and voluntary decision-making. But I do not believe parliament should attempt to impose a precise timetable on the progression of an individual person's disease.

Every illness, person and prognosis is different, and for those reasons I ask members to support the Leader of the Opposition's amendment to remove clause 19(1)(d)(ii). Keep the safeguards and the requirement for an advanced progressive condition expected to cause death, but please remove the clock.

I commend these amendments to the Assembly.

Madam SPEAKER: Procedurally, I have made a bit of a mistake. I should have given the Member for Fong Lim the call because his amendment comes before your amendment, and if we vote on your amendment, he cannot raise his. Can we just park your amendment for a moment, Member for Arnhem, while we process his amendment and then we will come back to yours.

Mr SMELT: So, in terms of the order, even though the Leader of the Opposition was first …

Madam SPEAKER: No, it is because the Opposition Leader wants to amend a part of the clause which comes after the part of the clause that the Member for Fong Lim wishes to amend. It is not about—we will come back to yours, but we need to process or deal with your amendment, Member for Fong Lim, so bear with me. I apologise.

Dr RAHMAN: Madam Speaker, can I just clarify that I think my understanding is that for clause 19(1)(d)(i) I was deleting the word 'advanced' and that is why mine should have come first.

Madam SPEAKER: That is correct.

Dr RAHMAN: And in clause 19(1)(d)(ii) multiple people were seeking to strike something.

Madam SPEAKER: If we deal with the Member for Arnhem's before yours, we cannot do that. Procedurally, it has to go in order. I apologise. Is that acceptable to you, Opposition Leader? The Member for Fong Lim wants to amend 19(1)(d)(i) and remove the word 'advanced', and yours comes after that. I will proceed anyway. We will hear your amendment and vote on that and then go to yours directly. I apologise for the mix-up, but we will get to yours.

Dr RAHMAN: The amendment that I have proposed is essentially this: if as many people in this House feel we should get rid of 19(1)(d)(ii), the 12-month prognosis criteria, then it is necessary in my mind and good practice for us to replace it with something that defines what the word 'advanced' means. This is basically what it comes down to. This was not considered in the in the report because it did not need to be considered in the report. The report said that there should be no prognosis period. We unilaterally unanimously agreed on that. It was one of the first no-brainers that just flew through. All five members of the committee had no qualms with it. It is documented in the report.

The standard in the LCAC report was straightforward that first thing we should do was dispense with a 12-month prognosis. We accepted now that the Australian standard, which had little by little started to develop, had reached the point where we realised that 12 months was an arbitrary subjective number. Previous to 12 months, it used to be six months, which was an arbitrary subjective number. Now where the Australian law is up to is saying we should use the word 'advanced', which is also a subjective word, but that is the legal and medical test that is preferred by all the people that work in the space now.

There are two lots of subjective things: test A, which is 12 months, an arbitrary number and subjective; or advanced, a word that is also subjective. This definition for 'advanced' is not my musings based on what I think 'advanced' should look like; it is drawn directly from the ACT legislation. That was drawn after an exhaustive debate and came from the Queensland and Tasmanian legislatures thrashing this out exhaustively. They have divined 'advanced' under this three-pronged test. The key thing is that every part of

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this is subjective. That is the point that I made on Tuesday—terminality is subjective. Everybody knows that, but this is a better way of defining it than talking about 364, 365 or 366 days within which you are said to be dying.

All of the arguments put forward in our little procedural mix-up before still hold here. I firmly agree with the Members for Fannie Bay, Johnston and Arnhem. If this amendment is defeated, I will still vote in support of the amendment to simply excise the 12-month prognosis clause—expected to cause death within 12 months—because it has been superseded legally in both medical and legal literature.

Now that has been established as a better standard, it makes sense for us to define 'advanced' in the legislation if we can. Frankly speaking, you could have the definition of 'advanced' in there, irrespective. It does not matter whether the 12 months is there; 'advanced' should still be defined now because it is something that we should be sweeping up from the latest lot of smart thinking on VAD laws.

For me, this is becoming a question of whether we care about anything that anyone in the rest of the country has said. If we do not, that is fine, but I do not know why we are going through this exercise. It starts to become redundant. There are no mountains of literature on why 'advanced' is better than '12 months' because it is on the edge of where the Australian law has come to, unlike the preceding defeated amendment on gag clauses where there are mountains of literature saying that gag clauses do not do what you think they do and just frustrate people. That idea has been settled now, much to my disappointment.

This is a smart inclusion in this legislation because if you do not define what 'advanced' means, we will be missing a trick; it is another hole in the legislation. From the top of this morning, it must be have been obvious to everyone that this is not a perfect law. A lot of things in it could be fixed, refined, rewritten and tidied up. It will require review and remediation.

In the meantime, people will be frustrated out of the process while we figure out the details, unless we get it right at the front end. There are people who are passionate about dispensing with this prognosis criteria because if you maintain that arbitrary 12-month timeframe—which is subjective the same as 'advanced' is subjective—you will end up having a much harder time getting doctors to satisfy the test for you. However, it is a pretty good test.

The key thing I point out is the third part of the amendment. The first two parts are pretty obvious. The first part is:

(ii) advanced, in that:

(A) as a result of the disease, illness or condition, the person's functioning and quality of life:

(I) have declined or are declining; and

Yes, we agree; somebody's life is going to pot:

(II) are not expected to improve; and

That is in alignment with all the other things to do with eligibility, and this is important:

(B) any treatments for the disease, illness or condition that are reasonably available and acceptable to the person have lost any beneficial impact; and

We have tried and we have failed over again. This is the extension of what we had before when we were essentially saying, 'We tried everything and it has not worked. This person has to be eligible.'

The final plank is the one that is important because the person still needs to be approaching the end of life. This is not about a situation where somebody has become exceedingly depressed because they have a medical condition which is progressive and expected to cause death, but they will not die imminently. They still have treatment options and a chance. Those people would not be eligible under these criteria.

'Advanced' is well defined in this amendment. The ACT spent a long time thrashing this out because it was a big call. That is the biggest development in VAD legislation that has occurred over a number of years now. The one that is playing out in the media now about telehealth is probably going to be the next battleground but that is not for our legislation today, so I will not speak to telehealth provisions at all.

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This is settled now. This is not novel, this is not newfangled, this is not woke, this is not progressive, this is just better law. Define the word 'advanced' and if you are going to meet the modern standard, get rid of 'expected to cause death within 12 months'. Once again, these two things are intimately linked. You cannot just knock out 'advanced' safely and sensibly without putting something in its place, or if you do you leave things open to interpretation which we should not do.

There is yet another silence in the legislation, yet another hole in the law that we are finding here. Alternatively do them both in one go and satisfy a really good safeguard because we keep talking about doing things to make things safe and proper, patient-led and making sure, well then let us do it. Let us actually make it the case that a terminally ill person, who has an advanced condition does not have to jump through an extra set of dumb hoops about the arbitrary nature of the number of days left before they die of X, Y or Z.

Of the three amendments I moved, I believed it was the most difficult to prosecute in some ways, because the evidence is still being developed, but it is definitely here and that is why I thought it was worth moving. The conscientious objection stuff, the gag clause stuff, should have been a no brainer in my opinion.

Obviously I accept the will of the House. We have decided not to adopt those standards, but it is not too late for us to, on this particular item, still restore the rights of the terminally ill. If you fail to do this part, we have to honestly and sincerely reconsider whether we have restored the rights of the terminally ill or whether this Bill is about something very different, which is still a noble thing. It is better for us to have a VAD law than no VAD law, but it is not restoring the rights of the terminally ill unless you get rid of this prognosis period and ideally put in a standard to define advanced at the same time.

Mr MACKAY: I am speaking to the amendment before us. I want to highlight that clause 19(1)(d)(ii) clause (C) that the Member for Fong Lim is proposing that requires the person is approaching the end of the person's life. A 12-month prognosis is a common thing. You have a reasonable chance of going in the next 12 months.

Madam SPEAKER: We are debating the amendment to the part of the clause before, expected to cause death within 12 months, which is 19(1)(d)(i) advanced progressive and expected to cause death—the deletion of the word advanced.

Mr MACKAY: Is it not a subsequent amendment that the Member for Fong Lim was just talking about the definition of though?

Madam SPEAKER: Yes, but it is not, for the purposes of what we are doing tonight, we have to deal with them separately. You can discuss them together like he has but we will be voting on them separately, and what we are debating there is strictly only his amendment. If it is the will of the House to vote on them together, someone could move that.

Dr RAHMAN: I have been doing precisely what you have indicated there. These two things can work independently and separately. The whole point is that you are absolutely right. I am only speaking at this point to 19(1)(d)(i) advanced; whether we delete the word 'advanced' from the first line, that is the first point to be voted on. That could go either way and irrespective of that, the subsequent one where advanced is defined can be discussed separately because both of them can be taken separately. I have discussed both because they are interrelated.

Madam SPEAKER: We will just move them one at a time.

Mr MACKAY: Can I still talk to the subsequent amendment? Is that the suggestion the Member for Fong Lim just raised?

Madam SPEAKER: Yes, you can.

Mr MACKAY: The person is approaching the end of life. When I have been talking to people about the 12-month prognosis period in particular, people are envisioning that if you get rid of it, as soon as you are diagnosed with something that is terminal, you will be eligible, or it will be a longer timeframe.

What these subsequent amendments would do is potentially restrict it to a short period before a person's death. You will need a doctor to sign off that the person is approaching the end of their life. For many conditions that might be the last couple months or weeks when you are approaching the end of your life. It is not that they have a five-year prognosis, so we will sign off on it; it is approaching the end of the person's life. That is what concerns me about trying to remove the word 'advanced' and insert the new definition.

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I am not saying that 12 months is perfect, but every other jurisdiction in Australia has moved to that 12-month prognosis period. For that reason I believe these amendments will actually make it harder for people to access voluntary assisted dying.

Mr MALEY: I am speaking about amendment 10, which will remove the word 'advanced'. If you do that without taking anything else, it will mean that the person must be diagnosed with 'progressive and expected to cause death'. It makes a nonsense of the clause. I say that you cannot just delete 'advanced' without amendment 11 as well. If we are only talking about amendment 10, I say that we cannot do that because it makes a nonsense of the legislation. If we are only voting on amendment 10, it will make it a nonsense. You could have a progressive condition expected to cause death, but have 20 years to live. You could have a skin cancer which may cause death because it is progressive. That word 'advanced' is important. We need to move the amendments together. If the removal of 'advanced' is successful and amendment 11 is unsuccessful, it would make it even more of a nonsense of that clause, read by itself.

Dr RAHMAN: If you read the clause it does not make a nonsense of it at all. It would read, 'The person must have been diagnosed with a disease, illness or medical condition that is progressive and expected to cause death'. That is what would happen if this amendment passed. In plain English, it makes perfect sense. These things can be taken separately, and they are two separate points. Obviously, they are related, but either could pass or fail.

I have been given the call on the basis we are prioritising this movement of the removal of the word 'advanced', so there is no reason why that cannot be the case.

The intention of my amendment is to remove a single word, which is just a single word that can mean a tonne of things, and leave it to be two separate criteria. The person must have been diagnosed with a disease or medical condition that is—ideally for me—progressive and expected to cause death, which means certain things. The second amendment is to insert 'advanced in that' and a comprehensive definition and a new legal standard test, albeit subjective as well, on what constitutes advanced.

There is nothing wrong with the legality of this, in my opinion.

Madam SPEAKER: The question is that amendment 10 be agreed to.

The Assembly divided:

Ayes 7	Noes 16
Mr Brown	Ms Boothby
J Davis	Mr Burgoyne
Dr Rahman	Ms Cahill
Mr Smelt	Mrs Carlson
Ms Uibo	Mr Charls
Mr Young	Mr Edgington
Mrs Zio	Mrs Finocchiaro
	Mrs Hersey
	Mr Howe
	Mr Kerle
	Mrs Lambley
	Mr Mackay
	Mr Maley
	Mr O'Gallagher
	Mr Patel
	Mr Yan

Amendment not agreed to.

Madam SPEAKER: We will go back to the Member for Arnhem's amendment 3 to clause 19.

Dr RAHMAN: We just voted on part 1, not part 2. They were not conjoined. I believe I can move amendment 11.

Madam SPEAKER: We need to go in sequential order. It is yours, then the Member for Arnhem's and then we come back to yours because that is the order.

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Ms UIBO: Just to clarify, to give the Member for Fong Lim comfort, mine is just removing clause 19(1)(d)(ii), which means that the Member for Fong Lim's amendment, which inserts a new subparagraph (ii), would still be eligible in this process. That is why, based on the advice, we are going in the current order.

Mr SMELT: I put on the record a couple of notes on this particular amendment about the timeframe. I think it is important, as has been noted by other speakers, that it is difficult to predict the prognosis timeframe. We also know that these kind of arbitrary timeframes can exclude many people who are suffering. It is an opaque process.

Dr John Zorbas from the AMA succinctly captures the essence of why this provision should be removed. He states:

> *A strict 12-month terminal prognosis requirement is clinically arbitrary and effectively unworkable in many medical scenarios.*
>
> *It will inevitably lock out patients whose specific disease trajectory is difficult to predict with exact certainty, but who will continue to experience intolerable suffering.*
>
> *We need legislation grounded in compassion, clinical reality, and the alleviation of suffering, not rigid timelines that ignore the complexities of terminal illness.*

I am not a doctor, clinician or healthcare worker, but I hope that statement rings for everyone in the House to reflect on. That is the view of the peak body for medicine in the Northern Territory. It is clear that this aspect of the law is not supported. There needs to be flexibility, judgement and a conversation between a patient and a clinician, not arbitrary timelines. This is why I support this amendment by the Leader of the Opposition.

Dr RAHMAN: A number of the arguments that have already been prosecuted in the relation to the arbitrary nature of picking a number. I have a practical point to raise first. The number used to be six, and now the number is 12. When we started this in Australia, it was mostly agreed that you had to be dying within 180 days. Now it is 365 days, for the most part and going in that direction on neurodegenerative conditions, oncology conditions and a range of other conditions. We have gone from one small restrictive number to a slightly more generous one. I note that the Member for Karama may break new legal ground if we get to the point where may get two years. The point is a number is a number, and it is arbitrary. For the record I will support that as well, Member for Karama, if that is what it come to.

Right now it is inconsistent with the principles of this Act. We have lost the wood through the trees on the purpose and the principles of this Act. It is a crying shame. This was meant to be about restoring the rights of the terminally ill. This was meant to be about giving terminally ill people commensurate access to voluntary assisted dying.

To what we had a long time ago—the original Bill passed 30 years ago. It did not have any of these checks and balances. It basically allowed doctors to be able to help people voluntarily have an euthanasia. We have come a long way since then, and we are meant to be adhering to the purpose and principles of the Act, which we all moved on the voices this morning. We are in contravention now, broadly speaking of the principles of the Act, if we maintain this Bill in the current form.

Section 4(E), a person approaching the end of life should be provided with high quality, person-centred care and treatment, including palliative care to minimise their suffering and maximise their quality of life.

Section 4(F), a therapeutic relationship between a person and the person's health practitioner should, wherever possible, be supported maintained. We are breaching the principles of the Act, in my opinion.

Will it be a good idea to pass this Act in some form? Definitely? It is a great framework of legislation to build upon in the future. We should not have had these principles. We should not have had these set of purposes. We should have basically cut and pasted the Victorian Act from 10 years ago. This is what we are essentially doing at this point.

For all the reviews, the independent enquiries, the going out bush, the trying to appeal to the hearts and minds, the standing side by side with the elderly, the seniors, COTA NT, the terminally ill, the medical professionals—all these stories that everybody told in the last few days and the heartbreaking stories about people who have died in suffering. I am not sure we are doing justice to them at this point.

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I ask everybody to think carefully about the fact that having maintained many safeguards that are not necessary, in my opinion, in this Bill, that we at least on this one provision allow this to still be a Bill to restore the rights of the terminally ill.

The original Rights of the Terminally Ill Act from 30 years ago did not say that you had to be dying within a specified number of days or minutes, or have a specified condition. This would at least give us credibility to say that this is what we have done. You just had to be dying before, and you had to find doctors who were willing to say that person is dying and suffering and wants to be helped to have a painless death—a right to be able to die on the own terms.

If we do nothing further on this Act, even if we pass on the other provisions which are restrictive—the Member for Drysdale has amendments coming up. Member for Karama has other amendments coming up. There are a range of other things that we still must consider even if we restrict the Act in other ways. Let this Act, let this service be available to anybody who is dying and is terminally ill. Do not make them jump one more unnecessary hoop. Forget the legalese arguments; just allow terminally ill, dying, suffering people to be able to get relief if that is what they choose—in keeping with the purpose and principles of this act.

Mr HOWE: I spoke about it in my speech. I think it is important to know that most of us have made our minds up about certain clauses. They are all informed from a variety of reasons. I spoke of conscientious objectors, I have been receiving those throughout the whole time. There are stories across the board, and we cannot keep coming back to the same arguments and putting guilt on other members.

This is a conscience issue. A lot of us have made our minds up. We have done that because of a particular reason, either for ourselves or communities. These safeguards are important for many in the community.

I will just leave it at that.

Mr YOUNG: Going to this clause, I support the Leader of the Opposition.

I just pick up—this is not about guilt. This House is to debate pieces of legislation and clauses and make an informed decision.

As I mentioned earlier, I was unsure about the clause. I made a decision when I heard the different debates within this House. It is not about guilting anyone. I found it highly offensive that you would say that. It is about having a genuine debate in the House, that is the purpose of why we are here.

Mr CHARLS: I have listened to the argument that a person may experience intolerable suffering for longer than 12 months. I accept that. There are conditions where suffering can be profound and prolonged, but that raises the very question we must answer as the legislators. Where do we draw the line?

Member for Nightcliff researched the peak body of doctors and their view, but in my view, this Assembly is the peak body of the legislation in the Northern Territory. We are talking about legislation, not an NT Health policy. For me, voluntary assisted dying must remain connected to the end of life.

If we remove the 12-month requirement entirely, we are no longer simply debating whether someone who is dying should have a choice about the manner and the timing of their death. We potentially extend that choice to someone who may have years of life ahead of them.

I accept that prognosis is not an exact science. A doctor cannot tell us with absolute certainty whether someone has 11, 13 or 18 months remaining. Uncertainty around a boundary is not, in itself, a reason to remove the boundary. This is an irreversible decision. Parliament therefore has a responsibility not only to provide choice but also to establish safeguards around that choice.

Twelve months provides a compassionate and reasonable balance. It recognises intolerable suffering, gives family and Territorians meaningful choice, and also preserves an important principle that voluntary assisted dying is an end-of-life option for someone approaching death.

I support voluntary assisted dying. I support the choice, but I also support safeguards. For me, retaining the 12-month prognosis requirement is an important part of maintaining that balance.

J DAVIS: I have been very impressed with how we have been working in this parliament today. I hope, listening to each other and taking on board what people are saying and not having come in here with our minds made up, because we could have just voted and saved everyone's time.

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The purpose of this is to make sure we are considering everything and making decisions based on what we hear in this House.

I want to give a specific example. We are talking about real people here. For example, a man called Tony Mims, he lives with Huntington's disease, he said publicly. He meets every eligibility criteria but one, that is the timeframe. Because of the nature of his illness, by the time he reaches the qualifying window, the cognitive decline that comes with that illness will mean it will have taken away his ability to make and communicate the request.

He will have unbearable suffering. He has no chance of recovery. He is going to die, and he will be prevented from making this choice.

These are decisions we are making about real people. They will impact on real people. I want us all to think about that when we are voting today.

Madam SPEAKER: Member for Arnhem, this is your amendment.

Ms UIBO: The contribution by the Member for Johnston was thinking about some of the situations that we grapple with as a reality in the Northern Territory. In my electorate of Arnhem, we have a rare and devastating disease called Machado-Joseph disease. It is rare in most parts of the world. The Northern Territory and Queensland are the few places in the whole of the globe that experiences this rare disease. I have family members who have this disease. In the Mulka electorate there is a small area where family members are affected by this disease. It is a hereditary disease. There is no cure for this disease, and it acts in a similar way to motor neuron disease.

If we are talking about a limitation on timeframe, such as a 12-month prognosis, when someone is diagnosed with MJD, the reality is they will lose all function of their muscles and will no longer be able to eat, speak or physically move on their own. Unfortunately, we are now seeing more Territorians with MJD receive prognosis of this devastating disease at a younger age. There is devastation to this disease, as a reality in the Northern Territory. To deny someone if they were to look at the option of VAD—I am not saying anyone of my family with MJD would have specifically asked for this. However, in thinking about the reality of what is experienced in the Northern Territory, MJD would be an example of a prognosis without necessarily the 12-month limitation if someone were to consider VAD as an option if they were diagnosed with this disease, which has no cure. It is a cruel disease with a fifty-fifty chance that you will inherit it if one of your parents has this disease. There is no changing that fact.

When we are talking about limiting somebody's ability to look at all medical options for their care or to alleviate their suffering—a terminal illness in this case, which obviously goes to the heart of the Bill—then this would be an example of why we need to remove the 12-month prognosis time frame.

Mr O'GALLAGHER: I have been struggling with this clause and amendment. I hear both sides. I can fully understand those who say, 'We should just get rid of it and let it go'. However, I also feel for those who say, 'Hang on, what about the safeguards? We needed safeguards here and we are opening a can of worms.'

I do not know, from my reading, whether people are prepared to go the full hog and just get rid of it, including me. Sometimes you err on the side of caution, if need be.

Having said that, people know that if these amendments are defeated, I will flag a compromise position where, instead of saying 12 months, we will go for two years. I will talk to that if I get to it.

Madam SPEAKER: The question is that amendment 3 from the Member for Arnhem on clause 19 be agreed to.

The Assembly divided:

Ayes 8	Noes 15
Mr Brown	Ms Boothby
J Davis	Mr Burgoyne
Mr O'Gallagher	Ms Cahill
Dr Rahman	Mrs Carlson
Mr Smelt	Mr Charls
Ms Uibo	Mr Edgington

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Mr Young	Mrs Finocchiaro
Mrs Zio	Mrs Hersey
	Mr Howe
	Mr Kerle
	Mrs Lambley
	Mr Mackay
	Mr Maley
	Mr Patel
	Mr Yan

Amendment not agreed to.

Dr RAHMAN: It is still important for us to define what the word 'advanced' means. Either way you have to define what the word advanced means or it means nothing.

Madam SPEAKER: You need to move your amendment.

Dr RAHMAN: My apologies. I move amendment 11 in the Amendment Schedule No 70 (Dr Rahman), Clause 19(1)(d)(ii). I have already expressed and articulated this. If our legislation is going to choose to be silent on provisions and we leave things to chance and not adopt what has been established in laws around the country through debates by the mature people, that is the decision we make, but we have just made a clear cut call on the fact that people should be approaching the end of their life. That is exactly what this amendment says; this is exactly what the definition says.

The Member for Sanderson raised a series of points with the concern that somebody would not be approaching the end of their life and be able to access a voluntary assisted death. Well, this is the antidote to that. The antidote to this is to simply say that you must have an advanced condition and that advanced condition is defined as follows; that you are getting worse, nothing is working, you are expected to die and it is going to happen soon.

There is no point in me re-prosecuting the totality of the clause. It is simply for the House to decide whether you would like to adopt the legal standard which has become the legal standard in Australian voluntary assisted dying law now noting that every single jurisdiction has learned from the last one since 2017 and improved voluntary assisted dying laws to the point where we are all approaching a coalescing Australian VAD model standard.

Mr MALEY: I will not be supporting the amendment. Earlier on in his contribution the Member for Fong Lim spoke about better law and being open to interpretation. We also heard today that doctors should be trusted, that they are professionals and that we have that confidence. I agree with that. My problem with this amendment is if we are going to trust doctors and leave things open to interpretation of better law, why are we defining just one word? Why are we just defining 'advanced'? Why are we not defining progressive, expected to cause death—and even in the amendment it has all sorts of definitions there. Why are we not defining them? When do we stop?

We have the word 'advanced', and there is a legal definition to that which doctors can find out. I am sure they will learn it. There is a whole lot of case law on what the definition of advanced is, so why are we only defining one word in this legislation? And if we leave things open to interpretation—which is what the Member for Fong Lim was saying; if we are worried about that we should not leave it open to interpretation, and we should define it. Even in the amendment, it has all sorts of definitions. Why are we not defining them? How far do we stop? We have the word 'advanced', and there are legal definitions of that which doctors can find out. I am sure they will learn them and, if they do not there is a whole lot of case law on what the definition of 'advanced' is. Why are we only defining one word in this legislation? If we leave things open to interpretation, which is what the Member for Fong Lim is saying, if we are worried about that we should not leave it open to interpretation, but define it. If you read his insertion, there are so many things there that should be defined as well.

Why I am not supporting it is we heard that doctors should be trusted; they are professionals. I think they spend seven years in university to get a degree and do all sorts of training. Leave it to them to work out whether it is advanced. If they want to work out what the definition is, there is case law. They can look up the Collins Dictionary—courts do that—and they can interpret it. I am saying that we should trust doctors.

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The second thing is, if we are to define one term, why not define a range of terms in this section? When we talk about open interpretation, in fact the amendment makes it even harder to interpret because there are three causes there now that need to be interpreted.

The Member for Goyder raised a good question. If the person is approaching the end of person's life, how do you interpret that? Doctors should do that. It is already included in the word 'advanced'. Why are we limiting doctors to legislation? I am saying let them use their training and expertise to stick with the legislation, which is 'advanced', 'progressive' and 'expected to cause death'. They are the experts. They can use their training to determine that and comply or not comply and meet the eligibility. Changing the legislation and putting the three clauses in creates a problem because it will open it for interpretation.

My second argument is why are we only picking one term? If you are to go down that path, why do we not define and have definition for all these terms to help the doctors? I say they do not need help, they are experts. Just a literal interpretation will be advanced, progressive and let the doctors decide.

I will not be supporting the amendment.

Dr RAHMAN: The answer to the questions raised by the Member for Nelson is because all of the other jurisdictions and other jurists have not thought fit to agonise over the meaning of 'progressive' or 'expected to cause death'. When they consider them, they said, 'Those words should be considered in the ordinary construction of those terms'. I did not make up the definition for advanced; other people thrash this out elsewhere. We are trying to use their best practise provisions. I did not dream up this legal test.

I am not claiming that I know any better. The reality of it is, not only do I trust our doctors, I also trust our jurisprudence, courts, law, and our legislatures elsewhere in the country.

The bottom line is that we were tasked, in the last LCAC inquiry with going out bush to consult. If you look at the terms of reference, we were also asked to look at what happens around the rest of the country, and recommend to all of you what we thought was best practise. That is what we did.

That is what the 2024 report did as well, and that was not good enough so we did a 2025 report. Again we looked at every jurisdiction and what happens everywhere and the legal tests. That is why we recommended, straight up, yes, prognosis is no longer required; 12 months can be dispensed with.

In the same breath, we should have probably adopted a definition for advanced then, because that is clearly where the legal and medical standard is up to now.

These are strawman arguments. Why have the not been defined? Because they were not in other jurisdictions. Should we be the most forward-thinking jurisdiction in the country? No, we should not. I keep saying that we are trying to keep pace with what the rest of the country does; that we should be doing what everybody else is doing and broadly not getting too far ahead or going 10 years back in time.

It appears that is not really what we are up for at the moment. That is a real source of disappointment, and it will be a source of disappointment to people who are terminally ill.

The cases that have been raised in some of the stories that have been told speak to who will fall through the cracks unless we define these words more clearly. We already know from all the case reports, literature and studies that the reason other jurisdictions have dispensed with prognosis criteria and gag clauses is to improve the law so that the people who want to opt in can and those who want to opt out can, and we have the balance right.

It is clear that there is not much appetite in this House for doing what is considered to be best practice in the country. We will have to settle for what is considered by this Assembly to be suitable practice for the NT, if we also reject this definition.

I take umbrage at the idea that these are just concocted words or definitions. I did not make this up. This is the best-practice stuff in the country at the moment. How did I find out? Because I chaired the inquiry with five others who were asked to look into it. Why are we talking about it? Because we provided the information to you. If nobody wants to adhere to any of that information, then so be it. Let the Territory have the voluntary assisted dying Act that it deserves.

Mrs ZIO: I have just one thing to add before we potentially vote on this last one.

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As a government, we have named this ‘Rights of the Terminally Ill’. We have we followed from what Marshall Perron implemented in 1995 and we have called it ‘Rights of the Terminally Ill’. If we leave it the way it is right now, we are not giving that title any justice. Maybe we should think about renaming it.

Madam SPEAKER: The question is that amendment 11 from the Member for Fong Lim be agreed to.

The Assembly divided:

Ayes 7	Noes 16
Mr Brown	Ms Boothby
J Davis	Mr Burgoyne
Dr Rahman	Ms Cahill
Mr Smelt	Mrs Carlson
Ms Uibo	Mr Charls
Mr Young	Mr Edgington
Mrs Zio	Mrs Finocchiaro
	Mrs Hersey
	Mr Howe
	Mr Kerle
	Mrs Lambley
	Mr Mackay
	Mr Maley
	Mr O’Gallagher
	Mr Patel
	Mr Yan

Amendment not agreed to.

Madam SPEAKER: We will have a quick five-minute break.

The Assembly suspended.

Mr O’GALLAGHER: I propose an amendment, which I tabled and as I flagged. This is a simple amendment to clause 19(1)(d)(ii), which currently specifies a 12-month prognosis requirement. I know we had the debate about whether we can get rid of it all the time, and I could see arguments on both sides. We had various advice from doctors, the Australian Medical Association, and I know people from COTA have been lobbying to get it removed. I can see reluctance on a number of members’ parts that they want the safeguards, and they have to feel confident with the safeguards.

Taking all that into account, I quote—I think the Member for Nightcliff did—Dr John Zorbas, as reported in the *NT News*, that to only allow patients to receive voluntary assisted dying services if they have been given a prognosis of death within 12 months is ‘clinically arbitrary and effectively unworkable in many medical scenarios’.

There is an arbitrary thing about whether you go six months, 12 months, two years, five years or get rid of it. There is something a bit arbitrary about that, but it is the unworkable bit that gets me. We should not have something that is unworkable in a practical sense.

I fully understand that the strong intent of this Bill is to ensure that there are appropriate safeguards and protections for the benefit of patients and the community, and that is what we are trying to get here. This amendment in no way reduces those safeguards or protections. I do not address them at all. All I am looking at is, yes, it is a bit of an arbitrary timeframe as well, but I think it is a more flexible one that I think addresses—it may not be perfect, but if people are saying that they cannot get it working really well for 12 months, they will have a better chance of getting it done with two years. I am trying to get a compromise. I know that we are all getting a bit tired, but we are having a conscience vote. Sometimes we have to ask whether there is a compromise, because if there is never a compromise, what is the point? It is just black and white. All I am asking is: is there a middle path that recognises the need to keep the protections and so on, yet just gives a little more leeway to address some of the concerns from medical professionals? You will not get everything you want, but we will give you a little more time to make it more workable. I think that is a good thing to do.

It is a simple amendment. I believe that if we do this, we will send a message to the health professionals and the wider community, a lot of whom want to get rid of the whole thing, that we are listening in part. We may not go all the way you want, but we are listening rather than just being dogmatic and saying, ‘No, we will not

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move on anything'. I believe the majority of Territorians would welcome this compromise. It is not what everyone wants; none of us can get everything we want. As an Assembly, if we show some sort of compromise, working together and say, 'We are not quite there, but we have listened to the community and the health professionals, and we have moved a little bit,' it will make the Bill more workable on the ground. That is what I want. It is being pragmatic. It is a bit like some of the other things. If I had issues about things not being enforceable, why do it. If you cannot make this work properly, we have a problem. If this simple amendment makes it work better, I urge you to consider it. I respect every member in this Chamber.

Dr RAHMAN: When I saw this amendment from the Member for Karama, I thought it was ridiculous. I thought, 'Sure, pick a number out of nowhere. We will just make things up as we go now.' Do you know what, Member for Karama, you are right, and I will support this amendment.

This is not the standard that could be set and should be set necessarily that I believe, but if we have any regard for the idea that we might be adaptive, flexible, a parliament of peers exercising a conscience vote, reflexive and that any of these speeches mean anything, we have to be able to take these things on their merits.

Member for Karama, I cannot wait for the VAD literature to start talking about the O'Gallagher standard. I find it astonishing that this is where we have landed. Do you know what? Member for Karama, I applaud your leadership and pragmatism in this space.

This is not how I wanted this to go, but I think it is a great thing that you have done because you are right; it will make it a bit more workable. It will mean that a few more terminally ill people will have fewer headaches qualifying for this. It will offer a few more people a bit more choice, even if some of the other things did not quite go the way that I hoped they would.

It is an arbitrary number, but in 2017 we started with six months in Victoria and then South Australia pretty much said six months as well. Little by little, everyone has shifted to 12 months. At first it was a little bit of six and a little bit of 12, depending on which disease you were dying of. By the time we got to Queensland, it was 12 months for everything. Everyone thought that made a tonne more sense. By the time we got to the ACT, we worked out that numbers are stupid, so let us use a proper definition for advanced.

We have not been able to agree on that as a standard for today, so fine; let not the perfect be the enemy of the good. There will be more good done in shifting that number from 12 to 24 months, so I wholeheartedly support your amendment, Member for Karama.

better if the prognosis part was removed. Given that has not succeeded in the Chamber today, I thank the Member for Karama for attempting to bridge that gap and strongly encourage people to support this because, as the Member for Fong Lim said, it means that a few people will have a better chance of being able to make the choice to die with dignity.

The Assembly divided:

Ayes 9	Noes 14
Mr Brown	Ms Boothby
J Davis	Mr Burgoyne
Mr Kerle	Ms Cahill
Mr O'Gallagher	Mrs Carlson
Dr Rahman	Mr Charls
Mr Smelt	Mr Edgington
Ms Uibo	Mrs Finocchiaro
Mr Young	Mrs Hersey
Mrs Zio	Mr Howe
	Mrs Lambley
	Mr Mackay
	Mr Maley
	Mr Patel
	Mr Yan

Amendment not agreed to.

Mr HOWE: I will be quick because I think I am the only member in support of this amendment. It is to omit clause 19(4)(c), the anticipation of suffering, from the definition of suffering. For me, this is a point of

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conscience. I am not sure how you anticipate suffering. If suffering itself is an anxiety of the mind, that is a form of suffering. It is a matter of conscience.

I move this amendment. I expect to be the only one for it.

I know how I will vote every time I come into this Chamber.

Dr RAHMAN: I will speak to this amendment which I will not support, but only because I think it is important that everybody knows just how hard the Legal and Constitutional Affairs Committee wrestled over the question of anticipatory suffering.

It was one of those where I philosophically am on the side of the Member for Drysdale. I struggled with the idea that you should allow anticipatory suffering to be included in the definition of suffering; I thought it was a bridge too far. However, ultimately, we came around and in the spirit of bipartisanship, I think it was the former Member for Nightcliff who somehow swayed the rest of us. I do not think I have breached any confidences—maybe I have—who knows?

The point is that anticipatory suffering is not an insignificant thing in terms of it moving the dial forward on VAD thinking and law and best practice. It is right on the edge of where Australians are willing to go.

We had conversations, for example, in the second reading debate about dementia, which we hear about all the time. We are all willing to concede that dementia is not a place where VAD can go in Australian law now. Until pretty recently, we all agreed on the fact that telehealth was a no-go as well. Who knows whether that will change again.

The point I am trying to make is that this is a moving feast. There is no fixed standard. The rest of the country has been reflexive and thought about what happened in the last place, tried to learn from it and passed the baton forward for everyone so that it makes it a little easier for the next place, with a view to, for the people who care about this space, coalescing a national standard. The hope and dream is the federal government eventually will take these headaches out of everyone's hands and basically adopt and settle a national standard. We are not there yet, and it might be a long time before it happens. I really do not know on that one. Maybe the telehealth restrictions will be the next thing to be seriously considered and part of our review going forward. That would certainly have a massive material impact on our Bill, given how much we heard about telehealth.

As a footnote, we decided that we can barely do a whole lot of things already in the criminal justice or health space reliably with telehealth. We did not recommend it in our report as a result. We said that if the standard moves that way, one day that will be fine.

We agonised over anticipatory suffering. With regard and respect for the Member for Drysdale, who I consider a person of conscience, principle, ideological backbone and fortitude—albeit one diametrically opposed to mine; we could not be further apart in the broad liberal tent, if you want to call it that—anticipatory suffering is worthy of consideration by everybody now it has been settled in this Bill. I have no idea how, frankly, but the bottom line is that it has made it into the Bill. I am happy to support keeping it in there, but I think it is worth noting, once again, that it was considered seriously. Despite robust discussion, ultimately, we came to a unanimous consensus position as a multi-party committee. Respectfully, Member for Drysdale, I will not vote for this amendment, but I think it shows courage to have brought it before the Assembly.

Mr MALEY: The Member for Fong Lim mentioned he hoped that the federal government would step in and make legislation about this. I am opposed to the federal government making any rules about the Territory. We have our own government. We are mature enough to make our own rules, so I disagree with that statement. We are here and we can make our own rules. I do not want what happened with VAD previously. It took us many years to get back to where we are. I reject the feds making any rules about the Northern Territory.

Madam SPEAKER: The question is that amendment 3 from the Member for Drysdale be agreed to.

Amendment not agreed to.

Madam SPEAKER: The question now is that clause 19 stand as printed.

The Assembly divided:

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Ayes 16	Noes 7
Ms Boothby	Mr Brown
Mr Burgoyne	J Davis
Ms Cahill	Dr Rahman
Mrs Carlson	Mr Smelt
Mr Charls	Ms Uibo
Mr Edgington	Mr Young
Mrs Finocchiaro	Mrs Zio
Mrs Hersey	
Mr Howe	
Mr Kerle	
Mrs Lambley	
Mr Mackay	
Mr Maley	
Mr O'Gallagher	
Mr Patel	
Mr Yan	

(division in previous turn)

Clause 19 agreed to.

Clause 20:

Mr KERLE: For someone applying to the Chief Health Officer to examine their residency exemptions, clause 20(2) says:

The Chief Health Officer must decide to:

(a) grant the exemption if satisfied … or

(b) otherwise – refuse to grant the exemption.

There is no time limit for the decision. As I foreshadowed, is there any recourse for the applicant if the Chief Health Officer does not make the decision in a timely manner, given that the Bill has fairly strict timelines for doctors to make decisions?

Ms BOOTHBY: The recourse is they can go to NTCAT. The CHO's intention is to set his review board up. He will be the Chair of that review board, of course, under the Act. His intention is to make swift decisions because it is in the best interests of the patient.

Clause 20 agreed to.

Clauses 21 to 83, by leave, taken together and agreed to.

Clause 84:

Mr O'GALLAGHER: My amendment, in Amendment Schedule No. 70 (O'Gallagher), seeks to amend clause 84(2), and there are consequential amendments to clauses 148 and 150.

My amendment relates to what is written on the death certificate in the case of a person who has voluntarily chosen, and has been approved, to access legal voluntary assisted dying services. The purpose of the amendment is to ensure that the death certificate truly records the cause of death, rather than being silent about it or trying to attribute it to a terminal illness that was not actually the cause of death.

I emphasise that I fully respect eligible people's decisions to choose voluntary assisted dying as a means to reduce pain and suffering from a terminal illness and to die with dignity, but the administration of an approved substance is the cause of death, not the terminal illness itself. That is the reality. If someone with a terminal illness was to die from a car accident just prior to dying from the illness, the death certificate would record the result of the car accident—for example, brain trauma—as the cause of death. That would be true because it was the actual cause of death.

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We must appreciate that death certificates are important. If someone chooses legal voluntary assisted dying the cause of death should be accurately recorded as being through the administration of an approved substance.

Let us not be afraid of telling the truth. It gets to me that we try to get around the truth because we think that it is a bit inconvenient or someone may not like it. The truth is the truth. If the truth is recorded on the death certificate in this example, history will show that person made an informed choice to end their pain and suffering with dignity and grace. It will show that they were capable and informed and there was nothing wrong with it, but they chose—no-one else chose—to use voluntary assisted dying to ease their pain.

Like birth certificates, death certificates are an important record of a person's life. I am worried that if we do not record the actual cause of death, we might as well say that all deaths are due to misadventure, and that would not be right because you need to be specific as to the cause of death. People who look back and do investigations want to know the actual cause of death.

Some people may be uncomfortable seeing it, but I have no problem with recording the truth, and the truth does not lie. If you worry about how somebody else reacts to the truth and disguise it that is not good enough and is wrong. It should go straight down.

I hear claims that this may affect insurance, so people will not tell the truth because they are worried about the insurance claim. If this legislation goes through tonight, and I am positive it will, every jurisdiction in Australia will have voluntary assisted dying. They may call it differently on death certificates, but we will have it. I do not think the insurance industry will be able to stand up to the fact that a legal form of death has been approved; it will have to adjust. If the insurance industry does not, we will need to get the federal government or whatever to adjust its legislation.

We do not adjust our death certificate legislation and birth certificates. They are true documents of what is really happening. When we look back in history we ask how people died. The certificate would say that someone died of cancer, but they did not; they made a constructive personal choice to end their pain and suffering. They were an informed person. It would also go down in history that they did not have dementia or anything, they were a sensible person who made their choice.

On that note, I commend the amendment to the Assembly. Let us be honest and bear the truth. Do not be scared of it, and let us go ahead.

Ms UIBO: I respect the Member for Karama's point of view, but I will respectfully not support this amendment.

Every jurisdiction in the country has rejected the proposal to record voluntary assisted dying as the cause of death on a death certificate. Many people would agree that voluntary assisted dying for an individual should remain private; therefore, on the public record it should remain that the condition for which the person had access to VAD is the cause of death. Voluntary assisted dying does not change the fatal condition or terminal illness someone is suffering; it just changes the timing and the manner of someone dying.

Although I respect the points put forward by the Member for Karama, this is not the time to put the Northern Territory on the back foot with this legislation. If every other jurisdiction in the country has rejected it for various reasons, I believe the Northern Territory should also do the same. We do not have to reinvent the wheel; indeed, we have not during this process.

The best outcome for people in the Northern Territory to have access to voluntary assisted dying should also create confidentiality and the space to have that process respected.

The Expert Advisory Panel on Voluntary Assisted Dying and the LCAC report also rejected this sentiment.

The Member for Karama acknowledged some of the reasons people have been concerned that an amendment like this has been put forward.

I do not think it is fair that if someone chooses, and goes through, the robust process of voluntary assisted dying that their families should be unable to claim funeral costs against funeral insurance, as an example. I do not think a family should be at a deficit because of the individual's choice, which should be respected.

It has been spoken about in different clauses for different reasons, but it could have the unintended consequence of exposing families and practitioners to adverse comments and harm, particularly, when

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someone has accessed VAD in small communities or towns where not a lot is private. This is one thing that can remain concrete for that person, past their death.

A person who accesses VAD was due to die from a terminal illness. That needs to be reflected and recorded officially on that person's health record, which anyone in the public domain can look at, research and have access to through the right privacy processes.

I respectfully do not agree with the amendment put forward by the Member for Karama and I will not support it.

J DAVIS: I thank the Member for Karama for bringing forward this amendment. I also will not be supporting it.

As we heard, every other Australian jurisdiction records the person's underlying disease as the cause of death, not VAD itself. Both the expert panel and the committee, after specifically weighing the transparency argument—which the Member for Karama spoke about—reached the same conclusion that the underlying condition is the medically accurate cause of death. Voluntary assisted dying changes the timing and the manner of the death, but it does not remove the terminal illness that made the person eligible in the first place.

We already do this in medicine. A great friend of mine recently chose to stop dialysis for end-stage kidney disease. Her death certificate records kidney disease. It does not record that she decided to stop dialysis.

We also know that recording VAD on a death certificate creates a real and practical risk of possible disputes or delays with insurance and superannuation death benefits, and that may be simply because the paperwork looks different.

A death certificate is not a private document. It is seen by family members and often used in a range of administrative processes. Recording VAD on it discloses a deeply personal medical decision through a document that was never designed to carry that information.

It is not hypothetical stigma. We know that the committee heard evidence that recording VAD as a cause of death can expose bereaved families to judgement and isolation, particularly in small or remote communities. It can also expose the health workers involved to blame or retribution.

In relation to oversight and honesty, none of this comes at the cost of oversight. Coordinating practitioners and other responsible parties will still be required to notify the statutory review board of every VAD death for compliance monitoring, safety review and public statistical reporting. That mechanism has worked consistently across every other Australian jurisdiction. The death certificate is not the right avenue for that oversight, so I will not be supporting the amendment.

Mr MACKAY: Regarding the amendment by the Member for Karama, my concern about the death certificates is more about the long-term effect on the dataset. It is a fact that over time, as more people access voluntary assisted dying and life expectancies show lower than what would have been achieved naturally—let me be frank, there is no shame in accessing voluntary assisted dying; it is a person's choice. However, we are talking about the death certificate, which is effectively the permanent record and how deaths are recorded in the register. It is important to think about that.

Le me hypothetically say that there is a specific type of cancer and, when you are at a certain stage, there is a prognosis of three years. At 12 months you will be able to access voluntary assisted dying. In 10 or 15 years, if a lot of people—it is a horrible disease—access voluntary assisted dying, the prognosis at that same point will be two years based on the best data available. In 30 or 40 years, it might change again.

The argument that every other state has rejected it because they do not want to have a fight with insurance companies and the superannuation benefits should not be the reason alone that we forge ahead by changing the record of people's death. It is a different choice from dying of that terminal illness or disease; it is a person's ability to die with dignity in the way they choose to go. That should be reflected on the death certificate. For that reason, I will support this amendment.

Mr HOWE: I will support this amendment. I do not think the arguments of the Opposition Leader or the Member for Johnston are, by any means, wrong; all those points are true. My view is based on the principle that our documentation and what we pass in here needs to reflect the truth. I also think that means there need to be proper changes. The biggest argument I find is in regard to the superannuation and insurance. The correct legislation should be amended so that people who use VAD can access those, instead of skirting around that issue through other legislation. I will be supporting it.

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Mr KERLE: I place on the record that I will support this amendment. I do not necessarily believe it will pass, but as a matter of principle I agree that birth certificates and death certificates are important and we should not enshrine into legislation an onus to lie on formal government documents. Yes, I understand it will cause all kinds of dramas with life insurance and superannuation. It might potentially breach the secrecy of how the person died, if they choose to have that. These are all things that will need to be worked through. We should not enshrine into legislation a requirement to lie on an official government document.

Mr YOUNG: I will not support this amendment. I strongly believe that when a death certificate is issued, the cause of death should reflect the illness or the disease that was the reason the person accessed voluntary assisted dying in the first place. I do not believe that it is a lie. I think it is a lie if we are not looking at the underlying disease or the illness, and that is what should be recorded for someone. For example, if someone has been diagnosed with terminal cancer, VAD does not change the underlying disease; therefore, it should be reflected in the death certificate itself. That is why I cannot support this amendment.

Dr RAHMAN: The committee wrestled with this and, ultimately, we were not experts in life insurance or the knock-on consequences. It came down to being guided by the evidence that we collected in lots of places. That is all cited in the final VAD report; you can trace it from paragraph 9.17 to 9.21, particularly the testimony collected—led by the Member for Blain—of the Tennant Creek Mob. We basically agreed on a settled position based on the evidence t received that, on balance, it was potentially bad for the terminally ill patient and inconsistent with the national standard. We wanted to do the right thing to maintain best practice.

Philosophically, everybody is sympathetic to the idea that it seems disingenuous to record something that is fictitious, but the legal standard in the country, the medical standard and the evidence we collected in the Northern Territory, which we were asked to make our recommendations on the basis of, clearly supported the provision as it is specified in the legislation currently.

Mr BURGOYNE: I will not support this amendment, but I will put on the record something that we have overlooked in the debate that has occurred so far.

This Bill is about the rights of the terminally ill. We are giving those people who wish to access VAD the ability to end their life with dignity. Through this entire debate today, we have argued about the timeframe in which someone can access it and the way that health practitioners can speak to people about it.

Make no mistake: when someone accesses voluntary assisted dying and takes it upon themselves to go through the process, there is no misunderstanding in the health practitioner's mind that person will die. The prognosis for which we have voted this evening ensures that in their mind the person will die from that terminal illness within the next 12 months.

By passing the Rights of the Terminally Ill Bill this evening, if that is the way members choose to vote, we will be allowing that person to choose the way in which they die and the timing of their death, which for that person means so much. For anyone who has seen someone die slowly and painfully from a terminal illness, there can be no doubt that pain is agonising and can be avoided.

This evening, although I respect there has been a respectful debate about the amendment proposed, I will not be supporting it. When someone chooses to access the rights of the terminally ill, when someone chooses to end their life through voluntary assisted dying, they are choosing to do so, not through any lack of truth in their life but to avoid what a health practitioner knows is a painful and agonising death. They are choosing to end their life in a way which gives them dignity.

Mr O'GALLAGHER: I thank everyone for their comments. I will just relate a little personal thing from my side of things. I lost my sister to bone cancer. She did not have access to voluntary assisted dying. She was an intelligent person; she could have made an informed decision, but I can tell you, her last three or four weeks were disgraceful. Essentially, they starved her to death.

I know that for her—and this is very personal—she would not have minded the death certificate saying, 'I chose to go by voluntary assistant dying, and I am happy for the world to know that I made an informed decision. I decided not to go through pain and suffering', which unfortunately she had to do. Although there may be some people who are worried about it, I am sure a lot of others would be proud to have recorded for history that they made that decision to have death induced through a drug, as opposed to saying it was the illness. What they want is the accurate cause of death.

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If you had a car accident two days before you were going to die, they would not put down the illness; they would write down the trauma or the result of the car accident as the cause of death, as they should. I fully respect where people are coming from. I am not having a go at anyone; I am just saying that I have an alternative view that is framed around the truth of what the real cause of death was.

Amendment not agreed to.

Clause 84 agreed to.

Clauses 85 to 107, by leave, taken together and agreed to.

Clause 108:

Ms UIBO: I move amendment 4 in Amendment Schedule No. 70OPP (Ms Uibo) to insert a new subsection after proposed section 108(1)(d).

The reason for this, as I outlined in my contribution to the debate on Tuesday—which many members would recall, hopefully—is better collection of data regarding palliative care services in the Northern Territory. Although it may seem simple, this is specifically focused on bringing further transparency to under-resourcing of palliative care services, which are likely to receive greater demand once voluntary assisted dying is introduced in the Northern Territory.

Approximately 1,200 Northern Territorians die each year. About 85% of these are predictable deaths due to a terminal condition for which people could benefit from palliative care. Voluntary assisted dying is a separate issue from palliative care. However, as we have seen in other jurisdictions, people may choose to receive palliative care throughout their VAD process. Palliative care in the Northern Territory is heavily under-resourced and access can be extremely limited, especially for those living in regional and remote areas.

This amendment is about legislating for the collection of that critical data regarding palliative care, alongside data including voluntary assisted dying access, so that all of us, particularly our health professionals, can see the demand for these critical services.

With this amendment, I am seeking to ensure that there is continued advocacy for increased resourcing for palliative care services alongside the implementation of VAD in the Northern Territory.

We learned from other jurisdictions that there has been an uptick in people accessing palliative care through the introduction of VAD. We can be smart and ready for this. I believe legislating to protect that important data collection of statistics in the NT means that we will be informed and can perhaps make improvements to ensure that more people can have the critical support of palliative care services. As I mentioned in my contribution to the debate on Tuesday, we do not have information about people who are unable to access palliative care due to limited resources.

I reiterate the phenomenal work that palliative care staff provide to Territorians and their families in that critical and distressing end-of-life period. My family has experienced that amazing care with some of our family, friends and loved ones. It is important to acknowledge the work those staff do. It would remiss of me not to acknowledge that.

This amendment would better enhance the support for that critical service, which is not necessarily often spoken about widely and publicly. However, this is the right opportunity to ensure that we can push for extra support for palliative care services in the Northern Territory through data collection and being able to have simultaneous data. We have seen an increase in other jurisdictions, so one can only assume, as the last jurisdiction to introduce voluntary assisted dying, that we will also navigate that.

The further you go from town into our regional and remote parts of the Northern Territory, unfortunately, the harder, or less attractive, it may be to access critical palliative care services. That may not be the staff; an individual or a family may feel that the palliative care service is too far from home and, therefore, not access that extra support and care.

I hope that all members can support this amendment. It will enhance the Department of Health's data collection. Doing it through legislation means that we will have that important set of data from the outset and can see some of the work already commenced through the implementation plan. If we support the Department of Health to do that through legislation, it will also allow for that reporting mechanism in annual

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reports and then, hopefully, a positive focus on increasing funding and support, which may lead to big decisions in the future about infrastructure, staffing and future policy to ensure that people in the Northern Territory have the best care when it comes to end of life, the staff have the best facilities and support, and families can look after and be supportive with their loved ones at the end of life.

I commend the amendment to all members. I hope that there is support for it.

Dr RAHMAN: A central focus of the committee's considerations was that we need to think about palliative care at the same time as voluntary assisted dying. It was so central to our minds that it was recommendation 3 of the report. We pulled no punches about the fact that it was necessary. The bottom line is that it was necessary for us to look at palliative care in tandem with voluntary assisted dying, the reason being that the data is unequivocal and unmistakeable. In every other jurisdiction, as soon as it passed voluntary assisted dying law, there was a massive uptick in the need for palliative care.

I prosecuted that case ferociously when questioning our Health department staff on 5 August. They were the ones who suggested that, yes, there would be orders of magnitude of extra funding and thinking required to make sure that we can properly cope with new demand. We know that there are innumerable systemic pressures on our health system. The minimum we can do, given the Bill is silent on everything to do with palliative care, is at least collect some better data. This is a pretty easy way of doing it.

I am happy to support this. This amendment, to me, looked inconsequential in the scheme of things initially, but any progress is good at this stage. I am keen for us to collect data that might help advise our strategy for palliative care going forward, noting that it will be affected by the passage of this Bill later tonight.

Mr SMELT: I support the Leader of the Opposition's amendment. Almost all members have spoken about the need for greater resourcing, support and planning for palliative care, noting the expected increase in demand after the passage of this Bill.

I encourage members to reflect on this amendment because we need that data. The independent review board is the best place for that. All departments collect, carry and maintain large sets of data. However, often when you have a particular query and ask, 'Can you tell me everything that happened in this case in this timeframe', it needs an army of public servants to run around and grab things from different places to compile a response to that simple data request. By charging the independent review board with the task to collect data about palliative care in addition to voluntary assisted dying data, it will make that process much easier; whenever the request is made, the data will be there. It is beholden on all of us to provide the independent review board with this power so that we can better understand the greater demand for palliative care, plan for it and, ultimately, deliver better resources.

Mr EDGINGTON: I oppose the amendment. The data included in this amendment is already collected through the Department of Health. We monitor those aspects of palliative care and there is no need to include it in the Act; we are already doing that work.

Ms UIBO: I appreciate the Member for Barkly's contribution about the amendment.

What is also missed, as I spoke about earlier, is the information about families and individuals who may be unable to access palliative care. That is also part of ensuring services and professional care are provided to Northern Territorians at the end of life and that there are options for those individuals and their families to ensure that even when someone cannot access palliative care, the data is still collected.

If the Member for Barkly does not support this amendment to improve data collection and statistics about palliative care, I am concerned that critical information could also be missed. Adding this to the functions of the review board will also allow the collection of data about not just those who access voluntary assisted dying but also those who access palliative care services or those who may be unable to access palliative care services for of a range of reasons. It is tunnel vision. It is narrow and wrong of the Member for Barkly to assume that is the data we need.

I implore members to support this amendment to clause 108 so that we can set ourselves up to be on the front foot when introducing voluntary assisted dying in the Northern Territory, ensuring that all the services are supported.

Dr RAHMAN: This is such an inconsequential ask in the grand scheme of things. I do not understand why we would oppose it. If we are here to try to improve the Bill and it is a conscience vote, it is not about letting an amendment moved by the Leader of the Opposition pass. We are collecting data. Our report made it

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1,000% clear that we could place a lot more attention on palliative care. This is just collecting and focusing our efforts to get some data; it will not materially change anything. It will not abrogate anyone's rights or create an extra headache for anyone. At the end of the day, it is only ticking a box on a form.

Once again, in the spirit of trying to make this the best Bill it can be, in whatever form that is, I support the amendment that has been moved.

Mr DEPUTY SPEAKER: The question is that the amendment be agreed to.

The Assembly divided:

Ayes 6	Noes 16
Mr Brown	Ms Boothby
J Davis	Mr Burgoyne
Dr Rahman	Ms Cahill
Mr Smelt	Mrs Carlson
Ms Uibo	Mr Charls
Mr Young	Mr Edgington
	Mrs Finocchiaro
	Mrs Hersey
	Mr Howe
	Mr Kerle
	Mr Mackay
	Mr Maley
	Mr O'Gallagher
	Mr Patel
	Mr Yan
	Mrs Zio

Amendment not agreed to.

Clause 108 agreed to.

Clauses 109 to 123, by leave, taken together and agreed to.

Clause 124:

Ms UIBO: The amendment I proposed to clause 108 was defeated. The amendment that I had drafted for clause 124 was a consequential amendment if clause 108 passed. Can I still move this amendment or has it become obsolete?

Mr DEPUTY SPEAKER: No.

Clause 124 agreed to.

Clauses 125 to 139, by leave, taken together and agreed to.

Clause 140:

Ms UIBO: Questions from earlier on today, Attorney-General, as you probably recall, were better suited for Clause 140.

You said in your second reading speech that you will be implementing a decentralised service model, rather than a centralised model as recommended by Northern Territory Health. Why have you gone against this advice from the Department of Health?

Ms BOOTHBY: I think I have already answered the question. It is up to the implementation under NT Health.

Ms UIBO: What benefits and disadvantages are there of a decentralised model?

Ms BOOTHBY: I answered that question already.

DRAFT

Ms UIBO: No, you redirected me to ask you in this section. I would appreciate an answer after waiting all day for it.

Ms BOOTHBY: Sorry, I was just getting clarification because I remember talking about this earlier.

This particular framework sets up the work that then can be informed by Health in that 18-month implementation plan. They will go through all that work during that time.

Ms UIBO: Can you guarantee that the decentralised model will be more efficient than a centralised model?

Ms BOOTHBY: No.

Ms UIBO: Hence my earlier question, what makes the decentralised model version more beneficial than a centralised model?

Ms BOOTHBY: As I said before, this legislation sets up the framework. It does not say anything about decentralisation or not. NT Health is now going through the implementation to determine how that works, and we have said it will be a decentralised model.

Clause 140 agreed to.

Clause 141:

Ms UIBO: With the review of the Act, I appreciate and note that some of those guidelines about timeframes have been included in the Act. That is very much welcomed. Is there a process or mechanism that has been outlined about what type of undertakings that review would also include, or has that not been decided yet?

Ms BOOTHBY: The clause does not limit the matters that may be considered in the course of the review, but requires a review to include consideration of the eligibility criteria and the principles of the Act.

Ms UIBO: Will there be public input into the review process or will that be determined by the Department of Health or by your Attorney-General's Department?

Ms BOOTHBY: It would be the determined by the Department of Health through that process.

Ms UIBO: Does the government envision that we will go down a road similar to the South Australian model, whereby the South Australian Health department provides what it calls a day of reflection, when there are essentially public hearings about voluntary assisted dying? That also collates into information for a review process and is included in the South Australian Health department's annual report. It is an open process and transparent, with the annual review. Would that be a possibility to feed into the three-year review commencement and then every five-year commencement that is outlined in this clause?

Ms BOOTHBY: That would be a matter for Health when it does the review.

Ms UIBO: In relation to the review of the Act, I note in proposed subsection (3) that the tabled report will be provided by the minister. Would that be you as Attorney-General or would it be the Health minister if the review is conducted by the Department of Health?

Ms BOOTHBY: We do not have the detail of which AAO it will be under yet.

Ms UIBO: Would there be the possibility of a joint tabling if it is across two different ministerial AAOs?

Ms BOOTHBY: It would probably depend on where it ends up landing and then be part of that implementation plan.

Ms UIBO: If the Department of Health is undertaking the review, but the Attorney-General is responsible for the Act—I assume it would still be the Attorney-General who is responsible for the Act—who would legally be required by the review provision, clause 141, to table the review?

Ms BOOTHBY: I understand what you mean because we have several Acts that are like that and we table things. It would be a matter for Chief Minister and Cabinet at the time.

Clause 141 agreed to.

DRAFT

Clauses 142 to 147, by leave, taken together and agreed to.

Clauses 148 to 166, by leave, taken together and agreed to.

Schedule agreed to.

Remainder of Bill, by leave, taken together and agreed to.

Dr RAHMAN: Madam Speaker, pursuant to Standing Order 162, I move that the Assembly reconsider clause 1 of the Bill at this juncture.

Madam SPEAKER: Clause 1?

Dr RAHMAN: That is correct.

Madam SPEAKER: I have to seek some advice.

The question is that the Assembly turn back to clause 1 for reconsidering.

Motion not agreed to.

Dr RAHMAN: Madam Speaker, as a point of order, I have been advised by the Clerk that I can speak to this motion at this point.

Madam SPEAKER: We just voted on it.

Dr RAHMAN: I have a script here saying. Under Standing Order 162, the Assembly reconsider clause 1 of the Bill'. I am to be provided a moment to explain my reasons for the motion. It is a motion and I believe I have …

Madam SPEAKER: Okay. We will go back a step. You moved a motion. You can speak to the motion, then we will vote on it. My apologies to everyone in the Chamber.

Dr RAHMAN: That is fine. Madam Speaker …

Madam SPEAKER: I would be nice to get the heads up about it, but never mind.

Dr RAHMAN: I apologise. I checked with the Clerk for that precise purpose.

It is admirable that we will pass the Bill. It is important that we went through the process we went through and considered amendments exhaustively. There is much to be proud of in the fact that we have a Bill that will provide a framework for some people to get access to VAD, full stop, in one form or another.

It is genuinely the case that this Bill no longer reflects its nomenclature. The long title of this Bill is that this is a bill to for an Act to provide for and regulate access to voluntary assisted dying, to establish the review board and for related purposes.

The short title of this Bill, though, is that this Bill may be referred to as the Rights of the Terminally Ill Act. I do not believe it does anymore in any meaningful sense. That is articulated in the case that was made when we made this recommendation.

We made this recommendation on the basis that the LCAC report basically said five things: that this was a report recommending that we put together a VAD Bill that did not require a prognosis period; that the NT Government develop a palliative care strategy; that we support a decentralised rather than a centralised VAD model; that we expand the parameters of institutional conscientious objection to promote cultural safety; and that we expand immunity from liability to a wider range of healthcare workers involved in VAD.

We have not done any of those things in this legislation as it stands now. This is still a good VAD Bill, but that is what we should be calling it now. This legislation should be called the 'Voluntary Assisted Dying Act 2026', as is the case in any other jurisdiction.

DRAFT

This is not anything other than being clear with Territorians about the fact that we are passing a Bill which is about VAD, but it is not the Bill that happened eons ago and it is not about affording rights to the terminally ill commensurate with what a lot of people are expecting. We have to be serious about this. I have a motion, which I do not think has been distributed by the Table Office. I will check with the Table Office.

Amendment Schedule No 2 that I have is to reconsider calling this the Rights of the Terminally Ill Act and instead call it the 'Voluntary Assisted Dying Act', because that is what it is. It is 100% a voluntary assisted dying Act at this point.

We made the recommendation because it was meant to pay homage to the past and the Rights of the Terminally Ill Act. A lot of people hold reverence for Marshall Perron moving this in the first instance. However, he has made it crystal clear that he does not want this Bill to be called the Rights of the Terminally Ill. This decision should not be made simply on the basis of his wishes, but just to be accurate. There is nothing wrong in the sense that this is a step in the right direction; there is progress for Territorians in passing this Bill, should we choose to pass it, and it will afford people who are terminally ill some protection and rights, but it does not reflect the scope of what was provided in that report.

It is worthy of consideration. This point was raised by a number of other speakers throughout the course of the debate. The Member for Fannie Bay raised it at one point in relation to a specific amendment. Other members raised it in other forms.

We would be doing a service to the Bill and to Territorians because we want to be honest about what is in the Bill and what we are presenting. Let us not pretend that it is the Rights of the Terminally Ill, 2026 edition, building on what we did in the past; rather, it is a new VAD Bill more in alignment with VAD legislation across the rest of the country and with the original Victorian and South Australian provisions, in some senses, although some things have been made different to reflect the unique circumstances of the Territory.

Voluntary assisted dying is what we are championing today. We are providing a mechanism for some people to access voluntary assisted dying. However, as I said, we are not providing the core recommendations of the report which made it clear that this really is meant to be about the rights of the terminal ill. We made it front and centre in the report because the thought process at the time was that these recommendations—these core, linchpin, load-bearing beams in the structure—be adopted. There was never a sense there would be any conflict about prognosis or conscientious objection, decentralised models, institutional conscientious objection or immunities.

On the balance of all that, we would still be passing a worthy Bill tonight and providing a VAD framework that acknowledges we are moving forward so that every state and territory in the country now has VAD legislation. Let us not be out of step with the rest of the country on this issue singularly. Let us not claim that this will be a Rights of the Terminally Ill Act with unique provisions. Let us make it clear that this will be a voluntary assisted dying Act.

I have circulated an amendment to this effect. I wanted to see what the scope of this Bill would be and what would happen through each amendment before we made that decision. I did not want it to be made prematurely …

Madam SPEAKER: Member for Fong Lim, you cannot move an amendment until the …

Dr RAHMAN: No, I am not moving that amendment; I am simply circulating it. To be clear, I am just circulating this paperwork.

Madam SPEAKER: Do you know that you cannot move an amendment until the Assembly agrees to reconsider the Bill under Standing Order 162?

Dr RAHMAN: Yes, I understand that. The reason I have circulated the amendment as drafted was to say that I had turned my mind to this. This is not something that I have suddenly dreamt up on the spur of the moment. I knew there would be legitimate concerns about the naming of the Bill and the inconsistency between the long and short title of the Bill if none of the amendments were agreed to.

I did not circulate it in advance because it had been my hope that some of the many amendments proposed tonight would have passed. Given that none of them, by anyone in any form, has passed, this is a narrow VAD Bill and not a Bill that reflects the rights of the terminally ill, is reflective of what happened 30 years ago or is even true to the reports upon which this Bill has been based. That is why I have distributed this, but I am not moving it. I appreciate that there will be a question put on whether we should reconsider clause 1.

DRAFT

There were scope of rights questions that we needed to resolve tonight about whether we would restrict information from individuals, different classes of people or institutions, and questions in relation to eligibility for VAD processes on prognosis. On the gag clause, there were scope of rights issues raised also on privacy, data protection and the recording of post-mortem information. These were all important considerations for us, as a legislature, to consider and make determinations on.

I respect the will of the parliament. The parliament has made a determination to keep the Bill unchanged. It is still a good outcome for Territorians to have a voluntary assisted dying Act. I want us to pass a voluntary assisted dying Bill tonight. I will be proud that we will be the first jurisdiction to pass a voluntary assisted dying Bill potentially unanimously, if there are no abstentions. That will be a first. Every other jurisdiction had debate, division, rancour and discord.

When we pass this Bill, I will cheer for its passing as well, because it is a step in the right direction. Of course, it is disappointing to me personally that some of the amendments did not pass, but I still believe that we are passing a good voluntary assisted dying Bill tonight.

To be fair to Territorians, the Bill's namesake, the committee report and all the hard work that went into it, all the inquiries and all the people who have spoken to this matter, we have to be honest with that the scope of this Bill is that it will be a voluntary assisted dying Act, not a Rights of the Terminally Ill Act.

Ms UIBO: What the Member for Fong Lim is putting forward is true and accurate. The debate and the process of consideration in detail has been respectful.

Noting that the draft amendment circulated goes to the intention of what the Member for Fong Lim was talking about, not necessarily an amendment that is being proposed, changing the name from the Rights of the Terminally Ill Act to the Voluntary Assisted Dying Act of the Northern Territory would make sense.

Through the consideration in detail process, multiple amendments were provided for all members to vote on with a conscience vote to improve the Bill. Unfortunately, as our democratic process stands, those amendments were not passed on the numbers, but each piece of work from every member has been considered and respected. However, it has not necessarily improved the rights of terminally ill Territorians to access voluntary assisted dying.

In light of that it makes perfect sense. It still reflects what the Bill does, which is to provide access to voluntary assisted dying. However, I concur with the Member for Fong Lim—all the work and contributions he has done—that it no longer reflects the rights of terminally ill Territorians to access voluntary assisted dying in its title. It would be disingenuous of all of us to think otherwise.

There was an amendment to ensure that Territorians who reside in a facility or institute would have the ability to access information and consultation about voluntary assisted dying in that facility if they are terminally ill, but it did not pass; the clause stands as printed and has been agreed to by the majority. Obviously we voted on it and there was division. That is disingenuous when it comes to protecting or providing the rights of terminally ill Territorians to access voluntary assisted dying support, care and service and medical professional support, care and service. It becomes a watered-down process by not having these extra improvements to the Bill.

I respect each individual could vote as they saw fit. However, I do not believe that it has been in the best interests of improving this Bill; that it provides the full rights that everyone would like to see when it comes to supporting terminally ill Territorians with this landmark piece of legislation; and that it has been a process to improve the Bill for the Northern Territory to be a frontrunner for this type of legislation and to consider every Territorian equally. There has been limitation, a narrow scope and pigheadedness in some of the reasons given. I still respect each individual's decision, but this is not a Bill that provides full rights to terminally ill Territorians. However, it does provide the introduction of voluntary assisted dying in the Northern Territory.

J DAVIS: Madam Speaker, I express my support for this. I wanted this idea and concept. I agree that we are today, wonderfully, about to pass a Bill bringing back something—every person in this Chamber should be so proud of the fact that we have this because everyone has contributed to it in some way.

It is a voluntary assisted dying Bill. We heard clearly from both the Member for Fong Lim and the Leader of the Opposition that it is not actually the rights of the terminally ill because there are terminally ill people who will be prevented from accessing voluntary assisted dying because amendments were not accepted in the Chamber tonight.

DRAFT

Mrs ZIO: Madam Speaker, I know we are all tired and want to get home, but I consider that because my name was thrown into the mix, I had better at least have a chat about it quickly.

Yes, I made the comment that maybe we should think about changing the name of the Rights of the Terminally Ill Bill, but I will not support the amendment. My reason for that is aspirational. There are review periods for this legislation. Three years after this Bill has been implemented in the Northern Territory, there will be a review process. Keeping the name 'Rights of the Terminally Ill' will give us something to aspire to and to reach and drive for in the future when those rights can be expanded and increased for people who need that support. That is my reason for not agreeing to this amendment.

Mr YOUNG: Madam Speaker, I acknowledge the Member for Fong Lim for bringing this forward. It takes some bravery to do this. I understand the reasoning behind why he would want to omit 'Rights of the Terminally Ill Act 2026' and insert 'Voluntary Assisted Dying Act 2026'.

We all heard the debates on different amendments this evening. I strongly believe that a big part of this Bill does not include those rights for many people, including the right for a doctor to speak to people and give them options—whether that is from palliative care to what medication they could go on and then having the right to talk about voluntary assisted dying. The prognosis of 12 months concerns me as well in that regard. This Bill is about voluntary assisted dying. I hope that in the future we strengthen this legislation.

Tonight is a real lesson. We should reflect that this is how legislation should be debated. We have all had our say in this debate. This is what we are elected to do as members of parliament. I do not agreed with where the Bill has gone in the end, but we have shown the best of all of us in being able to have that respectful debate across the Chamber.

I support what the Member for Fong Lim is putting forward.

Madam SPEAKER: The question is that under Standing Order 162, Reconsideration of a Bill, that the Bill be reconsidered in terms of clause 1.

Motion not agreed to.

Bill agreed to.

Ms BOOTHBY (Attorney-General): Madam Speaker, I thank everyone in the Chamber today for the conduct of this debate. The rights of the terminally ill is an issue that sincere people hold differing views about. We have all experienced that today. Many have lived experience as loved ones, carers and health workers. Many of us have deep and emotional connection to the issue.

There has been a robust debate and a challenge of ideas. That is what parliaments should do. We have shown that it is possible to simply agree to disagree. That is okay. In light of the sensitivity and the gravity of the subject matter, I commend everyone on the open and respectful way that we have debated. That is what Territorians expect.

Now Territorians expect us this to get this over the line. After three decades we will vote on the rights of the terminally ill. This achievement is only possible because of your determination, courage and kindness. It is an achievement that is far too long in the making.

Thank you to the Chief Minister for your leadership. Thank you to my CLP colleagues for your support and conviction as you represented all of your communities with all of your hearts. I thank you deeply for that.

Thank you to the thousands of Territorians, including in my own Attorney-General's Department and office, who have contributed to this debate over 30 long years.

With that, let me wrap it up. For 30 years Territorians have fought for the right to choose how and when they die. The federal government ripped that freedom away from us. Today we are restoring the rights of the terminally ill. We have spoken about it enough; it is time to give Territorians their freedom back.

I move that the Bill be now read a third time.

Motion agreed to; Bill read a third time.

DRAFT

ADJOURNMENT

Mr EDGINGTON (Leader of Government Business): Madam Speaker, I move that the Assembly do now adjourn.

Motion agreed to; the Assembly adjourned.

DRAFT