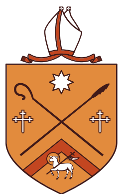

Anglican Diocese
of the Northern Territory

August 28, 2025

The Legal and Constitutional Affairs Committee
Legislative Assembly of the Northern Territory
Parliament House
Darwin NT 0800

Submission regarding Voluntary Assisted Dying

1. I am grateful to the Legal and Constitutional Affairs Committee for the opportunity to make this submission regarding Voluntary Assisted Dying (VAD). I make this submission on my own behalf and also on behalf of the Anglican Diocese of the Northern Territory (ADNT), following a resolution of our Diocesan Synod on August 23, 2025, which is provided as an appendix to the submission. I note the resources that the Legislative Assembly has provided around this issue including the Consultation Paper of July 2025 and the Short Consultation Guide: Parliamentary Inquiry into Voluntary Assisted Dying.

2. We do not support making VAD legal in the NT. As our Synod resolution indicates, we urge the Northern Territory (NT) Government and the Legislative Assembly not to pass such legislation for reasons now to be set out. We echo the resolution of the most recent Australian national Anglican General Synod in 2022 expressing its principled opposition to euthanasia and VAD.

3. I understand that the drive towards VAD in other jurisdictions arises from a sense of compassion for those who might be approaching death, who feel that their quality of life is deteriorating, who may be experiencing debilitating symptoms such as high levels of pain and anxiety, and who seek to have control over the end of their life. I also understand that a further driver in the NT is to be in step with other Australian jurisdictions.

4. Our first objection is that the termination of one's life is something that should be left to God not taken into human hands. Clearly this objection is based on religious principles, in our case the principle of the sanctity of human life because it is created by and comes from God, as expressed in the Bible. I understand that our society and particularly the vocal opinion-shapers in contemporary Australian society proceed in most ways from the assumptions of secular humanism. Under those assumptions humans are the highest point in decision-making autonomy. The concept of God, particularly as in the Christian, Jewish and Islamic religions, is dismissed or relegated to the domain of private and personal belief. I submit to the Committee that such humanist assumptions have no stronger basis than the religious assumptions that wider society relativises. Indeed, humanist assumptions suffer from the vested interest

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of humans wanting to determine their own destiny rather than having divine mandates and guidance to observe. I urge the Committee not to dismiss objections to VAD simply on the basis that they proceed from a Christian (or other religious) standpoint.

5. Apart from the religious objection, other more pragmatic considerations are relevant as objections.

6. In almost every jurisdiction where VAD (or equivalent) has been legalised, safeguards are put in place at the beginning, and much is made of them rhetorically by VAD proponents. With the passage of time, the evidence is that these safeguards are incrementally eroded. This has flow-on effects to the way VAD is implemented and thought about. VAD is made increasingly available to a wider group of people who find life difficult. Ironically, suicide prevention strategies are also encouraged. This sends a very confusing message. Ultimately it is difficult to see VAD as anything but undermining the principles on which suicide prevention stands. This is particularly disturbing given recent increases in the suicide rate particularly of young people. There is no reason to believe that the NT will not follow the same erosion of safeguards as other jurisdictions, and this erosion will have the same effects as elsewhere.

7. VAD inevitably changes the healthcare-patient relationship. According to the information in the Consultation Paper, the medical practitioner is placed in the difficult position of having to offer the patient death as well as health. As VAD becomes normalised, and the financial implications are observed, it seems highly probable that (whatever the initial legislative safeguards may be) there will be subtle pressure from medical practitioners for patients to undertake VAD. I have heard anecdotal reports of this in other countries where VAD has been legislated.

8. The medical practitioner must make an assessment of the probability that the patient's death will occur in the legislated time period. I have personal knowledge of many cases, and have heard of many more, where the medical prognosis for a patient was in the order of six months, and the person lived for many more years. For a patient to end their life when the prognosis is so wrong is a very poor outcome.

9. The relationship between patients and their families will be changed if VAD is legislated. Particularly when family will benefit from the death of the patient financially and in terms of time and energy devoted to them, it is easy to imagine subtle, even subconscious pressure being placed on patients to undertake VAD. If the patient is elderly, such pressure would constitute elder abuse even if this is not recognised. Further, patients themselves may opt for VAD because they are concerned about being a burden on their family, rather than because they really want to end their life. It is likely that in many situations, resources would be lacking to bring such pressures into the open, particularly as VAD becomes normalised. It is even imaginable in the course of time that the elderly and other patients would feel it is their positive duty to family and society to end their lives. This overturns both religious and humanist notions of the

inherent value of human life. If VAD is legislated, we urge the Legislative Assembly to introduce the strongest possible protections against elder abuse in the context of VAD, as well as protections for people living with physical or mental disability, pessimistic though I am that such protections would stand the test of time.

10. It is well known that the future is expected to bring much greater costs in the healthcare sector. The very poor financial situation of the NT Government is also well known. Taking the life of the patient through VAD will be a cost saving compared with the cost of longer-term medical care. The financial pressure on health services will strongly incentivise the implementation of VAD. As VAD is normalised and initial legislated safeguards inevitably erode, this incentivisation will rise. This undermines the notion that VAD is a genuine “free choice”.

11. The Consultation Paper notes the issue of the interface between VAD and palliative care. The Paper notes the Expert Panel’s Recommendation 17 is to provide adequate funding for palliative care, and the Consultation Paper asserts that resourcing of VAD should not be at the expense of palliative care resourcing. Recommendations of Panels and assertions of Consultation Papers, however, need not be followed. It is hard to believe that with the normalisation of VAD, pressure will not build to encourage the option of VAD, negating the value of human life. I accept that legislators may decide in good faith to vote for VAD believing that safeguards can be maintained and that the recommended funding for palliative care will continue, but indications from other jurisdictions contradict this.

12. We urge the NT Government to not only increase funding for palliative care services, but also to analyse and remedy inequities in provision of and access to those services across the NT, particularly in remote Aboriginal communities.

13. I am grateful that the Committee has sought input from remote Aboriginal communities, including Ngukurr which is one of the Anglican parishes in the NT. The ordained church leaders there have told me that they expressed at their local consultation their strong opposition to VAD. I am grateful that the Consultation Paper recognises the distinctive demography of the NT, including the higher proportion of Aboriginal people here than in other jurisdictions, and noting the higher proportion of Aboriginal people who are able and prefer to speak their own vernacular languages rather than English. I have spoken with all our Anglican ordained church leaders in the NT and they all express their strong opposition to VAD. The health situation in the NT is already complicated enough and difficult to understand for Aboriginal people. To add VAD would greatly increase the complications, and lead to a rapid erosion of trust in the healthcare system. Many attempts so far at communicating knowledge from the Western healthcare system to remote Aboriginal communities have failed, and this is well documented. There is no reason to imagine that the VAD system will be better communicated. The Consultation Paper’s words about “cultural safety” and “co-design” may be rhetorically pleasing, but they are very much harder to implement in

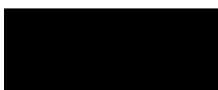
reality. If the Legislative Assembly seems inclined to legislate VAD I urge that it delay until actual concrete proposals are in place for cultural safety and co-design to be ensured, by dealing directly with Aboriginal people on the ground, not through Peak Bodies and ACCHOs.

14. If VAD is legislated, we urge that adequate protections are provided for medical practitioners who have a conscientious objection to VAD. The problem is again that other jurisdictions erode such initial protection and there is little reason to believe that the NT would not follow suit. The Expert Panel's Recommendation 4 is inadequate, requiring medical practitioners to advise about VAD even if they are not willing themselves to engage with it, and requiring residential facilities to enable VAD provision even if the residential facility is under the governance of entities for which the deliberate termination of life is unacceptable.

15. The Short Consultation Guide asks as its third and fourth questions for input as to how VAD can be accessed or delivered safely, which seems to smuggle in the assumption that it can be. I submit that for the reasons provided above, VAD is intrinsically and inevitably unsafe. The evidence from other jurisdictions such as Belgium, Canada and The Netherlands is that initial protections and safeguards are eroded or ignored. To deliberately end human life opens a Pandora's box. The Committee should give consideration as to why the death penalty was abolished in Australian jurisdictions. One major factor was the possibility of wrongful convictions, meaning that executions could proceed on a false premise. The NT has a particularly infamous wrongful conviction in living memory. As submitted above (#8), there is no guarantee that a medical practitioner's prediction of a patient's length of remaining life is accurate. A second major factor was the brutality that legislated termination of life expresses. This factor remains in place for VAD, denying the sanctity of human life.

16. In summary, we strongly urge the Committee, the NT Government and the Legislative Assembly to reject the reintroduction of VAD in the NT. It is a denial of the sanctity of human life created and determined by God. Its consequences, even outside a religious framework, are dangerous and potentially destructive of the most significant of human relationships. The provision of palliative care should be adequately funded as providing a vastly safer way for people to die with dignity.

Respectfully submitted,



Right Rev. Dr Gregory Anderson
Bishop of the Northern Territory

Appendix: Resolution of the Diocesan Synod of the Anglican Diocese of the Northern Territory, August 23, 2025

That this synod, noting

A. that the Bible teaches us that humans are created in the image of God (Genesis 1:26) and so have inherent value to God, and
B. that God has numbered our days (Psalm 90) and determines the limits of human life, and
C. that the 2022 general synod of the Anglican church of Australia reaffirmed its principled opposition to euthanasia or voluntary assisted dying,

1) urges the Northern Territory government not to pass any legislation supporting Voluntary Assisted Dying, and
2) requests the Bishop to make a submission on behalf of the diocese to the Legal and Constitutional Affairs Committee including, but not limited to,

a. expressing our concern about Voluntary Assisted Dying as it is the taking of human life with a lethal injection,
b. requesting consideration of thorough conscientious objection provisions at an institutional and personal level,
c. asking for protections against possible elder abuse, and abuse of those with physical or mental disabilities,
d. asks the Committee to give consideration to the inequity of palliative care access in the Northern Territory.

Moved: Rev Kristan Slack / Seconded: Dr Mick Tong — Carried unanimously