Submission to the Legislative Inquiry on the Attorney-General Legislation Amendment (Boards, Committees and Statutory Offices) Bill 2026

Australian Medical Association Northern Territory

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Introduction

This formal submission is presented to the Legislative Scrutiny Committee of the Northern Territory in response to the inquiry into the Attorney-General Legislation Amendment (Boards, Committees and Statutory Offices) Bill 2026 (Serial 65). As the peak professional body representing medical practitioners and advocating for public health across the jurisdiction, the Australian Medical Association Northern Territory (AMA NT) is committed to ensuring that legislative reform is guided by robust clinical evidence, patient safety science, and rigorous clinical governance. The primary policy objective of the Bill is to streamline operations and improve public sector administrative efficiency by abolishing or merging several boards, committees, and statutory offices within the Attorney-General's portfolio. However, a detailed public health and clinical governance evaluation reveals that several proposed amendments introduce severe risks to child protection, patient rights, clinical oversight, and the independent regulation of alcohol-related harm in the Territory.

The AMA NT bases its analysis on the core principles of preventive medicine, evidence-based policy, and corporate and clinical transparency. Clinical practice and public health science demonstrate that administrative efficiency must never be pursued at the cost of robust safety frameworks, independent oversight, or the protection of vulnerable populations. Consequently, this submission outlines strong opposition to the statutory abolition of the Child Deaths Review and Prevention Committee (CDRPC) and the Health and Community Services Complaints Review Committee. We also raise critical concerns regarding the relaxation of residency requirements for the Chairperson of the Northern Territory Liquor Commission.

The Northern Territory faces unique demographic, geographic, and socio-economic challenges, including remote service delivery complexities and highly vulnerable populations. Consequently, the institutional mechanisms designed to review adverse outcomes must be robust, transparent, and structurally independent of the direct operational lines of government departments.

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The Abolition of the Child Deaths Review and Prevention Committee (CDRPC)

Part 2 of the Bill amends the *Care and Protection of Children Act 2007* by repealing Chapter 3, Part 3.3, effectively abolishing the statutory basis for the CDRPC. Section 5(b) of the Act is also amended to omit references to this Part, and Section 13 removes definitions inextricably linked to the Committee, such as the 'Child Deaths Register'.[1] The Explanatory Statement argues that the CDRPC's statutory functions will be carried out by appropriate Government agencies and the Coroner's office, intending to reduce overlap and create greater alignment with the coroner's functions. The medical and epidemiological evidence demonstrates that this constitutes a regression in child mortality prevention and public health strategy.

Historical and Public Health Imperative of the CDRPC

The CDRPC was not established as a routine bureaucratic exercise; it was formed in 2008 in direct response to the landmark NT Parliament's Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse report, internationally recognised as the *Little Children are Sacred* report.[2] The objective of the committee, as enshrined in the legislation, has been to assist in the prevention and reduction of all child deaths in the NT by maintaining a comprehensive register, conducting and sponsoring research, and developing targeted public health policies.[3] The transition toward a formal, multidisciplinary child death review process represented a paradigm shift from a legal and forensic response to child deaths toward a comprehensive public health model.[4]

The CDRPC analyses the broader socio-economic, medical, and structural determinants surrounding a child's death. Child mortality in the Northern Territory is a critical and ongoing public health crisis. The CDRPC's annual reports continuously highlight that Indigenous children living remotely make up the vast majority of child deaths in the NT.[5] For instance, longitudinal data indicates that over three-quarters of recorded child deaths were Indigenous children, and nearly two-thirds occurred outside the Greater Darwin area.[5]

The epidemiology of these deaths is complex and deeply rooted in the social determinants of health. The underlying causes of child deaths in the NT highlight persistent disparities in perinatal conditions, congenital malformations, external causes, and severe infections.[6] The rates of intentional self-harm and suicide among Aboriginal youth in the NT have historically been recorded at levels exponentially higher than the national average.[6] By dismantling the CDRPC, the government removes the only independent, multidisciplinary body specifically tasked with translating these tragic statistics into preventative public health policies.

The Fundamental Distinction Between Coronial and Public Health Review Models

The government's primary justification for abolishing the CDRPC rests on the premise that its functions overlap with the NT Coroner's Office and can be absorbed to enhance governmental coordination.[1] This argument reveals a deep misunderstanding of the science of fatality review

and the distinct methodologies employed by forensic and public health systems. The Coronial model and the Public Health Child Death Review (CDR) model serve entirely different (albeit complementary) purposes within society.

The Coroner's statutory mandate is predominantly investigative and medico-legal. A coroner seeks to determine the identity of the deceased, the time and place of death, and the medical cause and manner of death, issuing written findings with recommendations for change where applicable.[7] While coroners are empowered to make preventative recommendations, their focus is inherently reactive, centering on the specific forensic circumstances of reportable deaths. Reportable deaths are generally defined as sudden, unnatural, violent, or suspicious deaths.[7] Consequently, a significant percentage of child deaths; such as those caused by the expected progression of congenital diseases, pediatric cancers, or severe systemic infections; are not reportable to the coroner, meaning the coronial system will never review them.[8]

In stark contrast, the Public Health CDR model evaluates all child deaths in the jurisdiction, regardless of whether they cross the threshold for coronial investigation.[9] The public health model evaluates systemic risk factors, social determinants, primary healthcare access, and the efficacy of longitudinal family interventions across multiple government agencies.[4] The CDRPC seeks to answer not just the mechanical question of how a child died, but the systemic question of why the death occurred and what failures permitted the vulnerability to persist.[8]

The following table synthesises the profound functional disparities between the two models, illustrating why one cannot simply absorb the duties of the other without catastrophic data loss:

Systemic Feature	**Coronial Investigation Model**	**Public Health CDR Model (e.g., CDRPC)**
Primary Objective	To legally determine the identity, cause, manner, and exact forensic circumstances of an individual death.	To identify systemic risk factors, aggregate longitudinal data, and formulate public health policies to prevent future child deaths.
Jurisdictional Scope	Restricted to unexpected, unnatural, violent, suspicious, or custody-related deaths.	Encompasses **all** child deaths, including expected deaths resulting from chronic disease, congenital anomalies, or infection.

Review Methodology	Forensic, legal, and pathological. Conducted primarily by police, forensic pathologists, and legal officers through an adversarial or inquisitorial legal framework.	Multidisciplinary and epidemiological. Conducted collaboratively by paediatricians, psychiatrists, social workers, educators, and Indigenous health experts.
Systemic Output	Individual judicial findings, legal determinations, and specific case recommendations addressed to individual agencies and government.	Aggregated epidemiological data, ICD-10-AM trend analysis, and broad, systemic public health policy interventions.

Shifting the burden of child death prevention entirely to the Coroner's office constitutes a reliance on a reactive, tertiary system. It represents a fundamental step backward from the internationally recognised best practice of establishing dedicated, multidisciplinary public health review teams, a standard adopted across the United States, the United Kingdom, Canada, and New Zealand.[8]

The Paradox of Coronial Reliance on the CDRPC

The legislative assumption that the Coroner can effectively absorb the CDRPC's preventative policy role is contradicted by recent Northern Territory Coronial history. Coroners often rely on the systemic research, aggregated data, and public health expertise generated by bodies like the CDRPC to formulate their own judicial findings and recommendations.

A stark example of this interdependence is the recent *Inquest into the deaths of Baby K, Baby B and Baby S 2026 NTCC 06*.[9] This inquest investigated Sudden Unexpected Death in Infancy (SUDI) occurring in unsafe sleeping environments, specifically examining the cultural context of co-sleeping and bed-sharing among Aboriginal families in the Northern Territory. In formulating recommendations, the Coroner explicitly cited the work of the Child Death Review and Prevention Committee, noting the Committee's specific recommendations to the RCAP Forensic Pathology Advisory Committee regarding the implementation of a uniform and consistent classification for cause of death for SUDI and unsafe sleeping environments.[9]

Furthermore, the Coroner relied on the systemic gaps identified by public health reviews, including the lack of culturally relevant educational materials regarding the 'Triple Risk Model' and the absence of safe sleeping devices integrated into Aboriginal language health promotion.[9] The Coroner depends on the dedicated, multidisciplinary epidemiological output of the CDRPC to inform systemic inquest recommendations. It is administratively impossible for the Coroner's office, operating within its legal and forensic constraints, to self-generate this

level of public health data in the absence of the Committee. Abolishing the CDRPC thus weakens, rather than strengthens, the Coroner's capacity to protect the public.

It is worth noting that this same inquest explicitly recommended to the Northern Territory Government that it "re-establish a comprehensive Child Death Review Process with all necessary expertise and resources to complete the process, to make recommendations and publicly report on deaths, findings, recommendations and outcomes.[9] This is the purpose of the CDPRC that this legislation would abolish.

The Imperative of Multidisciplinary Clinical Expertise

A fundamental pillar of medical advocacy regarding child protection and mortality review is the absolute necessity of clinical leadership and multidisciplinary collaboration.[10] The statutory membership of the CDRPC has historically included paediatricians, psychiatrists, Aboriginal health experts, and child protection professionals appointed based on their specific clinical qualifications and community experience.[2]

Prominent medical leaders, such as Associate Professor Robert Parker (a former President of the AMA NT and senior psychiatrist with extensive experience) have served on the CDRPC. The presence of active clinicians brings decades of expertise in Indigenous health, pediatric development, and youth suicide prevention to the systemic review of child fatalities. The complex epidemiology of child deaths in the NT cannot be addressed by a single governmental department operating in isolation. The medical nuance required to differentiate between a non-preventable physiological tragedy and a systemic failure in primary healthcare access requires active clinical practitioners at the review table.[8]

When clinical expertise is removed from the statutory oversight architecture and relegated to closed departmental processes, the NT risks returning to the opaque, siloed environments that pre-dated the *Little Children are Sacred* report. As noted by international public health research comparing child death review processes across six countries, the structure of a CDR team is critical; while structure alone does not guarantee success, the absence of dedicated funding, legislative backing, and multidisciplinary clinical input severely hinders the translation of fatality data into life-saving prevention.[11]

AMA Policy Alignment on Child Maltreatment and Fatality Review

The AMA has consistently advocated for robust, national, and jurisdictional-based child death and injury databases that are insulated from political interference and integrated with comprehensive reporting functions.[10] The AMA's position statements on child abuse and neglect emphasise that physicians have a profound ethical obligation to treat, protect, and advocate for vulnerable children. Medical professionals possess both "downstream" obligations as mandatory reporters and forensic documentarians, and "upstream" obligations to support systemic interventions that prevent abuse and neglect before they result in fatal outcomes.

The AMA supports systems that guarantee a fair, multidisciplinary assessment of adverse events, ensuring that medical, social, and legal contexts are fully integrated. By removing the statutory mandate for the CDRPC, the NT Government is fracturing the collaborative intelligence network that tracks intentional self-harm, medical neglect, and SUDI trends in the

Territory. The AMA NT concurs with the deep concerns expressed by child protection advocates and medical practitioners that disbanding this committee will leave "serious gaps" in our understanding of why NT children die and how these tragedies can be systematically averted.

The Abolition of the Health and Community Services Complaints Review Committee (HCSCRC)

Part 4 of the Bill amends the *Health and Community Services Complaints Act 1998* by repealing Part 9, which currently establishes the Health and Community Services Complaints Review Committee (HCSCRC). Section 4 of the Act is correspondingly amended to omit the definition of the Committee, and Section 97 is amended to remove confidentiality provisions related to Committee members.[1]

The Explanatory Statement attempts to rationalise this repeal by asserting that the Review Committee possesses a "very narrow function," has "not found significant or ongoing procedural concerns" since 1998, and provides "little value" given the existence of other complaints and review processes, specifically citing the Australian Health Practitioner Regulation Agency (AHPRA). A critical evaluation of these rationalisations reveals them to be flawed. The abolition of the HCSCRC represents a degradation of procedural fairness, natural justice, and independent oversight within the NT health system.

The Critical Role of the Review Committee in Procedural Fairness

The HCSCRC was established under Section 78 of the *Health and Community Services Complaints Act 1998* to oversee the procedural fairness of the Health and Community Services Complaints Commission (the Commission).[12] The Committee is statutorily empowered to review the conduct of a complaint, determine whether proper procedures and processes were followed by the Commissioner, monitor the operation of the Act, and make recommendations for administrative improvement to the Minister.[3]

Procedural fairness is a foundational tenet of administrative law and medical regulation.[13] It guarantees that any individual or entity subject to a complaint (such as a medical practitioner, a clinic, or a hospital) has the opportunity to be heard by an unbiased decision-maker, and that the investigative process is transparent, timely, and free from prejudice. Conversely, it ensures that aggrieved patients and their families receive a thorough, impartial assessment of their grievances.

The Review Committee's membership is uniquely structured to ensure structural balance, statutorily comprising a legal practitioner of at least five years' standing (serving as Chair), two representatives of service users, and two representatives of service providers. This composition ensures that when the Commission fails to communicate adequately, delays investigations unreasonably, or denies a practitioner the right to respond to allegations, an independent panel equipped with clinical, legal, and consumer expertise can hold the Commissioner accountable. Removing this committee concentrates unchecked investigative and regulatory power in the hands of the Commissioner, fundamentally undermining the

principles of administrative justice that protect both the public and the profession.

Jurisdictional Distinctness: The Flawed Argument of AHPRA as a Substitute

The most concerning administrative argument presented in the Explanatory Statement is the claim that the HCSCRC is of little value because of the presence of AHPRA.[1] This assertion demonstrates a fundamental conflation of two distinct regulatory jurisdictions that serve different functions within the healthcare ecosystem.

AHPRA, in conjunction with the National Boards (such as the Medical Board of Australia), regulates *individual registered health practitioners* under the Health Practitioner Regulation National Law, focusing heavily on professional registration, serious misconduct, and fitness to practice.[14] By contrast, the NT Health and Community Services Complaints Commission (HCSCC) possesses a vastly broader remit.

Jurisdictional Feature	**AHPRA & National Boards**	**NT Health and Community Services Complaints Commission (HCSCC)**
Primary Scope of Regulation	Individual registered practitioners (e.g., doctors, nurses, dentists, pharmacists).	Health service providers, healthcare facilities (hospitals, clinics), non-registered practitioners, NDIS providers, and systemic institutional issues.
Type of Complaints Handled	Professional misconduct, clinical impairment, severe performance deficits, and fitness to practice.	Service delivery failures, access to medical records, facility policies, billing disputes, and institutional treatment standards.
Focus of Regulatory Outcome	Practitioner registration status, imposition of conditions, suspension, or cancellation of registration.	Conciliation between parties, provider policy changes, formal apologies, compensation, and systemic health reform.

When a patient raises a grievance regarding systemic failures at a hospital, a dispute over the

release of medical records, or the conduct of a non-registered healthcare worker (such as an allied health assistant or alternative medicine provider), AHPRA has no statutory jurisdiction. These matters fall exclusively to the HCSCC. If the HCSCC mismanages these complaints, acts with bias, or denies natural justice to a health facility or patient, AHPRA possesses neither the power nor the mandate to intervene in or review the Commission's administrative processes.

Therefore, abolishing the Review Committee removes the *only* statutory oversight mechanism designed to scrutinize the HCSCC's administrative procedures. The AMA NT stresses that AHPRA operates as a co-regulator with defined national boundaries; it is not an appellate or administrative review body for state and territory health complaint commissions.[15]

AMA Position on Medical Regulation and Complaint Handling

The AMA NT is critical of poor complaint management systems. Lengthy, opaque, and procedurally flawed investigations cause profound psychological distress, professional burnout, and the adoption of defensive medical practices among doctors, ultimately degrading the quality of patient care.[13] The psychological toll of an unstructured or indefinite complaint process cannot be overstated, with practitioners frequently citing a lack of communication and an assumption of guilt as primary stressors.

The AMA has consistently advocated for robust clinical and legal oversight of health ombudsmen and complaint commissions across Australia.[13] In evaluating the performance of health complaint entities, the AMA emphasises that fairness requires an independent structure that checks investigatory overreach.[13] The AMA's public positions explicitly call for an impartial, external complaints handling mechanism and assert that procedural fairness must be embedded in the architecture of regulation, not treated as an afterthought.[13] Furthermore, the AMA has advocated strongly for transparency and the provision of options for persons under review, particularly the right to appeal or seek review of administrative actions.[16]

If a medical practitioner in the NT believes they have been denied natural justice by the HCSCC the practitioner's current recourse is to request a review by the HCSCRC. Without this Committee, the practitioner has no accessible, cost-effective administrative review mechanism and may be forced into expensive and protracted Supreme Court litigation for judicial review. This imposes an unacceptable financial and emotional burden on the medical workforce in a jurisdiction already facing immense challenges in attracting and retaining highly specialised clinicians.

Administrative Attrition: The Pretext of the "Dormant" Committee

The Explanatory Statement implies that the Committee's lack of recent findings justifies its abolition. It posits that the Review Committee, "having not found significant or ongoing procedural concerns... is therefore of little value". However, independent scrutiny of parliamentary records and public commentary reveals that the absence of findings is not indicative of a flawless complaints system, but is rather the result of administrative neglect by the government itself.

Recent parliamentary questions and media investigations indicate that the Attorney-General

permitted the Review Committee to become entirely dormant.[17,18] The tenure of the previous Review Committee expired in late October 2024, and the Attorney-General subsequently failed to appoint new members or constitute a new committee. Consequently, the Committee has not met, and aggrieved parties attempting to access the statutory review process have been structurally denied the ability to do so because the body was left unpopulated.[18] Public reporting has highlighted the recent frustration of a Territory citizen who attempted to escalate complaints only to discover the oversight body had been left non-functional.[17]

To argue that a statutory oversight committee provides "little value" and finds "no concerns" because the responsible Minister systematically starved it of membership is a highly disingenuous justification for legislative repeal. The AMA NT views this method of 'abolition by attrition' as a breach of administrative faith with both the medical profession and the Territory public. A functioning health complaints system requires active, adequately resourced, and populated oversight bodies to maintain public and professional trust.

Analysis of Additional Statutory Amendments

While the primary focus of the AMA NT's submission concerns the severe public health and procedural fairness implications stemming from the repeal of the CDRPC and the HCSCRC, the Bill contains several other administrative amendments across different portfolios.

Electrical Safety Act 2022

The AMA NT does not hold set viewpoints on these proposed changes, given that they sit outside the sphere of healthcare.

Liquor Commission Act 2018

Part 5 of the Bill makes an amendment to the *Liquor Commission Act 2018*. Section 8 of the Act is amended to remove the words "or the Territory," effectively allowing the Chairperson of the Northern Territory Liquor Commission to attend meetings remotely and fulfill their duties if they are travelling outside the NT.[1] This is a standard modernisation reflecting contemporary remote work capabilities and technological advancements, improving operational flexibility without altering the regulatory authority of the Commission. It is imperative however, that the legislation requires the Chairperson to be normally resident in the NT. To effectively administer the Liquor Act 2019 and lead the Commission, the Chairperson must have an on-the-ground, lived understanding of these local realities. Allowing the statutory head of this critical regulatory body to routinely govern from interstate risks decoupling its leadership from the immediate clinical and community impacts of its licensing decisions.

Public Trustee Act 1979

The AMA NT does not hold set viewpoints on these proposed changes, given that they sit outside the sphere of healthcare.

Risk of Conflation

The AMA NT acknowledges that the amendments to the *Electrical Safety Act*, the *Liquor Commission Act*, and the *Public Trustee Act* appear to reflect genuine efforts to reduce

administrative friction and modernise government operations without compromising human life, public safety, or natural justice. The AMA NT raises no specific medical or public health objections to Parts 3, 5, and 6 of the Bill. However, the benign nature of these specific administrative changes must not be utilised as a legislative shield to pass the highly detrimental provisions contained in Parts 2 and 4. The preservation of a robust child death prevention framework and the maintenance of procedural fairness in health complaints represent fundamental pillars of a safe society; their dismantling cannot be equated to the administrative clarification of GST on Public Trustee management fees.

Conclusion and Legislative Recommendations

The *Attorney-General Legislation Amendment (Boards, Committees and Statutory Offices) Bill 2026* presents a significant risk to the public health, safety, and administrative justice frameworks of the Northern Territory. Under the guise of streamlining statutory offices and reducing bureaucratic overlap, the Bill systematically removes independent, clinical, and multidisciplinary oversight from the most sensitive and vulnerable areas of public administration: child mortality prevention and medical complaint handling.

The proposed abolition of the Child Deaths Review and Prevention Committee (Part 2) defies the internationally accepted public health model of fatality prevention.[8] The Coroner's Office, whose mandate is forensically and legally focused on determining the medical cause of death for a limited subset of unexpected fatalities, is neither designed nor resourced to conduct longitudinal, multi-agency epidemiological reviews.[7] Coroners themselves rely on the systemic output of the CDRPC to formulate recommendations regarding culturally appropriate interventions for issues like SUDI.[9] Dismantling the CDRPC will blind the Territory to the systemic socio-economic factors driving child mortality and youth suicide, particularly among highly vulnerable Indigenous populations.

Similarly, the abolition of the Health and Community Services Complaints Review Committee (Part 4) removes the sole statutory mechanism for ensuring the Health and Community Services Complaints Commission adheres to the principles of natural justice and procedural fairness.[12] The argument that AHPRA serves as a viable alternative oversight body demonstrates a fundamental misunderstanding of the differing jurisdictional boundaries in health regulation. Furthermore, citing the Committee's recent lack of activity as a rationale for its abolition, when parliamentary records indicate the Committee was actively left unpopulated and dormant by the government, undermines the integrity of the legislative process and denies medical practitioners a vital avenue for administrative review.

The AMA NT firmly asserts that public health surveillance and procedural fairness in medical regulation are not redundant layers of "red tape" to be cut in the name of administrative convenience. They are the essential structural foundations of a safe and accountable healthcare system.

Based on the extensive medical, epidemiological, and legal evidence detailed in this report, the AMA NT submits the following actionable recommendations to the Legislative Inquiry:

1. **Reject Part 2 of the Bill:** The Legislative Assembly must vote to strike Part 2 from the Bill in its entirety, thereby retaining Chapter 3, Part 3.3 of the *Care and Protection of Children Act 2007*. The Child Deaths Review and Prevention Committee must be preserved, adequately funded, and empowered to continue its vital multidisciplinary public health mandate to protect the children of the Northern Territory.
2. **Reject Part 4 of the Bill:** The Legislative Assembly must vote to strike Part 4 from the Bill, thereby retaining Part 9 of the *Health and Community Services Complaints Act 1998*. The Health and Community Services Complaints Review Committee must be maintained to ensure systemic accountability and natural justice for both patients and medical practitioners.
3. **Immediate Appointment of Review Committee Members:** The Attorney-General should immediately execute their statutory duty to appoint suitably qualified members to the currently dormant Health and Community Services Complaints Review Committee to restore functional oversight to the Territory's health complaints system.

The Northern Territory must not retreat from its commitment to protecting its most vulnerable children and ensuring administrative fairness for its dedicated healthcare workforce. The legislature is urged to act in accordance with established medical science, public health best practice, and the unwavering principles of administrative justice.

References

1. Northern Territory Government. Attorney-General Legislation Amendment (Boards, Committees and Statutory Offices) Bill 2026 (Serial 65). Darwin: NT Legislative Assembly; 2026.

2. Child Deaths Review and Prevention Committee - Attorney-General's Department, accessed on May 20, 2026, https://agd.nt.gov.au/attorney-general-and-justice/committees-and-boards/child-deaths-review-and-prevention-committee

3. ANNUAL REPORT 2023–2024 - Attorney-General's Department - Northern Territory Government, accessed on May 20, 2026, https://agd.nt.gov.au/media/docs/annual-reports/department-of-the-attorney-general-and-justice/agd-annual-report-2023-2024.pdf

4. Queensland Family & Child Commission, accessed on May 20, 2026, https://www.qfcc.qld.gov.au/sites/default/files/report-a-system-review-of-individual-agency-findings-following-the-death-of-a-child-2017.pdf

5. Indigenous kids living remotely make up majority of child deaths in the NT | SBS NITV, accessed on May 20, 2026, https://www.sbs.com.au/nitv/article/indigenous-kids-living-remotely-make-up-majority-of-child-deaths-in-the-nt/brebaip1k

6. NT Child Deaths Review and Prevention Committee - Attorney-General's Department, accessed on May 20, 2026, https://agd.nt.gov.au/media/docs/annual-reports/cdrpc-annual-reports/cdrpc-annual-report-2009-10.pdf

7. Investigating Child Protection Deaths - Queensland Law Handbook, accessed on May 20, 2026, https://queenslandlawhandbook.org.au/the-queensland-law-handbook/your-rights-and-responsibilities/coronial-matters/investigating-child-protection-deaths/

8. The importance of child and youth death review - PMC, accessed on May 20, 2026, https://pmc.ncbi.nlm.nih.gov/articles/PMC3887082/

9. Inquest into the deaths of Baby K, Baby B and Baby S [2026] NTCC 06 - Attorney-General's Department, accessed on May 20, 2026, https://agd.nt.gov.au/__data/assets/pdf_file/0004/1609456/Decision-Baby-S-Baby-K-Baby-B-Co-Sleeping.pdf

10. Royal Commission into the Safety of Children at Risk - Australian Medical Association, accessed on May 20, 2026, https://ama.com.au/sites/default/files/documents/royal_commission_into_the_safety_of_children_at_risk.pdf

11. Child Death Review Processes: A Six-Country Comparison | Request PDF - ResearchGate, accessed on May 20, 2026, https://www.researchgate.net/publication/259536087_Child_Death_Review_Processes_A_Six-Country_Comparison

12. Review into the structural models for - statutory integrity offices - Department of the Chief Minister and Cabinet, accessed on May 20, 2026, https://cmc.nt.gov.au/__data/assets/pdf_file/0010/1555939/2025-integrity-review-report.pdf

13. Office of the Health Ombudsman - Australian Medical Association, accessed on May 20, 2026, https://www.ama.com.au/sites/default/files/2022-10/OHO%20Issues%20Paper.pdf

14. Ahpra - Regulatory guide - Australian Medical Association, accessed on May 20, 2026, https://www.ama.com.au/sites/default/files/2022-03/Ahpra---Regulatory-guide---a-full-guide.PDF

15. Joint Submission from the Medical Board of Australia, the Nursing and Midwifery Board of Australia and the

Australian Health Practitioner Regulation Agency - Parliament of Australia, accessed on May 20, 2026, https://www.aph.gov.au/DocumentStore.ashx?id=b37693a2-a274-4510-ad69-251318bfdd7c&subId=415042

16. AMA calls for more transparency in Section 92 agreement process, accessed on May 20, 2026, https://www.ama.com.au/ama-rounds/24-december-2021/articles/ama-calls-more-transparency-section-92-agreement-process

17. 'It is just a big joke': Attorney-General left health complaints review, accessed on May 20, 2026, https://advocatent.au/it-is-just-a-big-joke-attorney-general-left-health-complaints-review-committee-dormant/

18. Legislative Assembly of the Northern Territory - Northern Territory Government, accessed on May 20, 2026, https://parliament.nt.gov.au/__data/assets/pdf_file/0007/1491244/Answer-to-Written-Question-10.pdf