The committee convened at 10.34 am.

INQUIRY INTO VOLUNTARY ASSISTED DYING
Barkly Regional Council

Mr CHAIR: First of all, thank you very much for helping to facilitate and organise today. We know it has all come together with the help of Georgia, Katie and Caroline in a short time. We will do a quick round of introductions before we do anything, so everybody knows who is who.

On behalf of the committee, we respectfully acknowledge the traditional owners of the country that we are on and pay our respects to elders past, present and emerging.

We appreciate everyone joining us here today and taking time to speak with us. We will get into it in a sec.

My name is Tanzil Rahman. I am one of the five members of parliament who are part of the Legal and Constitutional Affairs Committee. I am the Chair of the committee and these are my four colleagues. I will let them introduce themselves.

Mr KERLE: My name is Matt Kerle. I am the Member for Blain in Palmerston. I am another one of the members of the committee.

Mrs CARLSON: I am Oly Carlson. I am the Member for Wanguri, one of the northern suburbs electorates next to the hospital.

Mr CHAIR: Do you want to introduce yourself?

Mr YOUNG: Sorry; I was getting my meeting papers.

Hi, I am Dheran Young, the Member for Daly. I represent the communities of Berry Springs, Wagait Beach, Dundee right down to Daly River out to Wadeye and Pine Creek.

Mr CHAIR: I think it is Pennie and Gregory and co. You guys want to introduce yourselves to us so that we know who you are and in what capacity you are representing here. Pennie first or maybe Gregory. Go for it.

Ms COWIN: I am Pennie Cowin, a Patta Ward councillor.

Mr MARLOW: Greg Marlow, also a councillor in Patta Ward.

Mr CHAIR: We have here with us as well?

Mr HOLBROK: I am Len Holbrok. I am from the local authority for Tennant Creek.

Mr CHAIR: Fantastic; thank you, Len. Of course?

Mr VASHIST: Thank you, Dr Tanzil. Sid Vashist, Mayor of Barkly Regional Council. There are apologies. Patta has five council members. There are three who are not here. One is Councillor Sharen Lake. She sends a message; when it is best I will read that message out. There are apologies from Councillor Dianne Stokes and Councillor Valda Shannon. There has been a passing last night in the community. There is some business happening in that regard—some sorry business.

Mr CHAIR: We understand. We appreciate that things can change and everybody has made themselves as available as possible. Sometimes we are speaking to one person and sometimes to a room of a hundred. It is good to have everybody to speak with, so we are very grateful for everybody who has made time today.

I will start off by explaining a little bit about the nuts and bolts and housekeeping and then get into what we are talking about. We have come today to talk to all of you about voluntary assisted dying specifically (VAD). That is the process of giving somebody a prescribed substance to help cause their death when they are terminally ill, at their request. It is a process that gives an eligible person—not just anybody—the choice to ask for medical help to end their life in a manner and time of their choosing.

We know that talking about this stuff can be very difficult for a lot of people. We know that talking about death and dying can cause people to feel upset. If you ever need a break or you want us to slow down, or if anybody

needs access to support services, we also have them on hand here, which can be provided by our parliamentary staffers, Caroline Williams, Georgia Eagleton and Katie Helme at the side there.

As you can see, we are also recording this meeting. We are doing so because we want to use the record of this as part of our information to contribute towards the report we are trying to write. If there is anything you want to tell us that you want to keep private and do not want on the record, please let us know and we can accordingly exclude that portion of our discussion. As I said, we are talking about a lot of sensitive issues. Sometimes people have sensitive information they want to share.

Finally, this is a formal proceeding of the committee, so all the protections of parliamentary privilege apply here, as they would if we were in the fancy room in Darwin.

I will explain the rough context of what we are talking about so we are all on the same page. As some of you who have been around a while will remember, back in 1995 there was voluntary euthanasia law that was passed in the Northern Territory. The following year, in 1996, the federal government intervened and they nixed that law by making it the case that territories could not make laws about euthanasia. Fast-forward to 2022 the federal government's position on that changed and it became possible for Australian territories to make laws about euthanasia and voluntary assisted dying, as it is more commonly referred to now.

Since 2017 the other states of Australia started passing voluntary assisted dying laws because there was a groundswell of support for it in each of those jurisdictions. It started in Victoria and now every state and territory in Australia, except the Northern Territory, has a voluntary assisted dying law.

Last year, under the direction of the previous Labor government, an independent expert inquiry was tasked with putting together a report. This is the 2024 expert inquiry Report into Voluntary Assisted Dying. Once this report was done nothing happened with it, so the current government asked this committee made up of people from three different parties—one Green member, who sends her apologies as she cannot be here today; Dheran is a member of the Labor Party; and the three of us are members of the CLP. We are all collectively working together to look into this report and see what we can add to it and whether, in fact, we should move towards having a voluntary assisted dying law in the Northern Territory as well.

To date our remit has included having to write a consultation paper, which is sort of a summary of this and where we think things are going. We have been asking for people across the Territory to provide us with written submissions and verbal submissions, and they have been coming in thick and fast as well. They will come in until the end of this week. We also, in the last parliamentary sittings, produced an interim report to let everybody know what we were doing and what the next steps were.

Over the month of August a big part of what we were asked to do was to go out to remote communities and basically get off the beaten track and ask people out in remote and regional areas what they thought about this because there has been the suggestion that there was not necessarily as much consultation as there could have been on these issues with people out bush.

That is basically why we are out here today, to hear from people who are representatives, councillors, TOs, everyday people and anyone who is out and about in the Northern Territory to find out how they feel about voluntary assisted dying, whether they think it is something that we could move forward with. Then we also have a bunch of sort of questions around all of this that we would like to ask you all about things to do with services out here because voluntary assisted dying, whilst it is a separate thing interacts, as you know, to some extend with palliative care, people who are in the last stages of living, aged care, healthcare generally. We would like to know a bit about how those services are functioning out here at the moment as well to give us a picture of what could also possibly be done with voluntary assisted dying.

That is sort of the background, so with that I think it would be useful to hear from any of you on any of these issues just as an introductory statement, if you like. I am mindful that you have some background things to read as well. If you want to put them on the record, now is as good a time as any, or if you want to just generally speak about issues first.

Mr VASHIST: Thank you, Tanzil. I will open the floor if it is okay with you. To those online, I am mindful Councillor Pennie is juggling 10 different things at the same time. Councillor Cowin and Councillor Marlow, if you want to speak. Councillor Cowin first?

Ms COWIN: Go, Greg.

Mr MARLOW: I was going to say you are the busy one and you might need to be called away, so you can go first.

Ms COWIN: For me, this is just more information. That is, for me, exactly what this is, because obviously I am in the position where I may be asked, here in this role. Any information I can forward on to the pharmacist as well, if required—information only.

Mr CHAIR: Of course, yes. We are here to answer questions. It is a two-way process for us, so if you have specific questions we can also go to them. We are just happy to hear from you guys in general to start with and then we can have more of a conversation and dig into some stuff.

Ms COWIN: Yes. At the moment I have no questions yet.

Mr CHAIR: Okay; no problems, Pennie.

Mr MARLOW: From an introductory point of view, I will offer a criticism of the federal government from 1998 or whenever it was. To me, even though we are a territory government, they should never have been able to withdraw the democratically elected or democratically voted Bill that was created in the Northern Territory. Just because we were first and just because we were a territory should not have given them the right to have our legislation withdrawn. Proof is, 20 or 30 years later, every other state has got legislation in place. We led the way, and now we have not got legislation and we are thinking about putting it back in place. I will leave it at that.

Mr CHAIR: Councillor Marlow, there are a lot of people who certainly do express a similar sentiment. There is the substantive issue of voluntary assisted dying and people having access to it. There is also the issue of whether territories should be able to make their own laws, so we are mindful of that argument; it does come up. Thank you for sharing that.

Mr HOLBROK: I am not a particularly religious person, although you never know who is up there …

Mr CHAIR: You never know.

Mr HOLBROK: But as long as it is not compulsory, I do not have to—if we get a VAD introduced in the Northern Territory, it is up to the individual to decide. I know my wife—I can speak for her—she would be deadset against it. She is firmly Roman Catholic. I would not say I am an agnostic; I am a Lutheran, but I am Father John's best friend.

I would like to see the legislation, but it is not something which is utmost in my mind. I am 86 years old and you never know what is happening tomorrow, but I just hope it can be a bus and it will be quick.

I do not hold with VAD.

Mr CHAIR: There are not many people who are pro-suffering, but there are people like your wife who, for a religious or cultural reason, are not necessarily pro-VAD and the hastening of death specifically either. We are happy to hear from people on all sides of the debate to help inform the debate.

Mr HOLBROK: If I had known about this a few hours ago, I could have brough another half a dozen people up here from the seniors' association. My wife is part of that.

Unidentified speaker: You are meeting separately.

Mr CHAIR: We are meeting them separately, I believe, from ARRCS.

Unidentified speaker: We are meeting them? That is all right. Otherwise, I was going to say we have that online for written submissions.

Mr HOLBROK: We could have brought all sorts of community groups in here, but that is not the point.

Mr CHAIR: Just on that, sorry, it turns out that between 1 pm and 3 pm when we were expecting some of those seniors, we have not actually heard back from them specifically …

Ms WILLIAMS: Sorry, can I just speak?

Mr CHAIR: Please go for it.

Ms WILLIAMS: The senior citizens, we asked them to meet with us and we did not hear back from them. If you think they would be keen to talk to us, we have got a drop-in session here at 3.15 pm if they wanted to drop by. I know it is late notice, but if they would like to do that, that would be terrific.

Mr HOLBROK: Okay (inaudible) phone call.

Mr CHAIR: That is good to know. If we can get a few extra key bodies, that is—every extra person is helpful.

Mayor, why do we not hear from you as well and the messages …

Mr VASHIST: Absolutely, Tanzil. Firstly, on behalf of Barkly Regional Council, we really appreciate the opportunity to facilitate this, the Department of Legislative Assembly and you all being here. Thank you very much.

I will begin with a couple of elected members, the first one being Councillor Sharen Lake. She wishes this to remain confidential. It is a conversation that we will have. Councillor Sharen Lake is currently away in Adelaide looking after her father. She is pro the introduction for voluntary assisted dying, with a caveat that is a common theme, the caveat being it needs to be an option—not a mandatory thing, but an option where people have choice. That is the message from Councillor Sharen Lake.

We have another member from Tennant Creek Local Authority …

Mr CHAIR: Just pause there. Is it just that portion that you want kept confidential, Councillor Sharen Lake's …

Mr VASHIST: Yes.

Mr CHAIR: That is fine.

Mr VASHIST: Her willingness to share her personal story about her father.

Mr CHAIR: Gotcha.

Mr VASHIST: We wish that remain confidential, but her stance is …

Mr CHAIR: That is fine; just to be clear.

Moving forward again, we are on the record, so go ahead.

Mr VASHIST: Thank you, Tanzil.

We have Russell O'Donnell, a Tennant Creek Local Authority member. It is the same sentiment—support, but a caveat of an option.

The Indigenous councillors from Patta—I am very mindful they are not here—for religious views and cultural reasons, they were very hesitant to discuss this in a public domain. The message is this is something that they have heard for many decades, most of these being elders. They remember this, they know what it is about, but one of the feedback was it needs to be done right and give us the privacy for having these conversations.

From my point of view, this is something that is very important and I commend the committee. Thank you for initiating the conversations. We should have a choice. The Territory should have their own powers in this regard. From the people that I have consulted with, I am hearing the same story here. With the Indigenous people I have interacted with, they wish to welcome you to the communities. They wish to have you interact with them directly.

I do not know how to word this properly, but in a way that interpretation and the language where people have a better understanding in how to go about this, because there is misinformation and disinformation and this needs to be tackled. To tackle that you will need the support of Aboriginal interpreter services. When you are going out in the communities, the communities, once they have a better understanding, is something I think community will potentially get behind, but they need to be consulted on the ground.

Councillor Ben Neade popped in today from Elliott. His conversation is something quite similar—'I do not want to talk here; I want to talk in my community.' That is why he just came and said to you hello and goodbye. He would really like to have—there are a lot of ageing people and a lot of elder people in the communities around the Barkly, and these ageing and elder people they do not have the guidance or the support.

I know that you are not restricting this to VAD only; you want to hear the conversations around service delivery of palliative care and the aged-care sector in the Barkly. Whenever you want I can actually discuss that matter with you as well, where things are at in our communities and in Tennant Creek.

Mr CHAIR: Why don't you start by telling us a bit about that? That is helpful to understand the context.

Mr VASHIST: Absolutely. The aged-care sector is under significant stress all around the Northern Territory; we know that. In the Barkly we have a limited amount of beds for our transitional people who are potentially going into palliative care. People are actually moving out of country and they are relocating to Alice or somewhere else, which is a huge no culturally. Sometimes there are issues around renal patients who potentially do not want to see the importance in renal anymore; they want to go back to country. That is another thing that has been flagged. These conversations need to be held and have a better understanding around that.

With the aged care, our infrastructure is very limited. We need to have more beds. I think you guys—I have gone through the schedule, so I was satisfied. I was hoping that all these people have said yes to you and they are meeting; otherwise, I would have proactively made sure that the seniors, just as an example, attend this because they were on the schedule, it looks like they have not responded. I am hoping that—have you got responses from everyone else or is there something?

Unidentified speaker: There were a few people who did not respond or (inaudible) to meet, but we did get a lot of messages as well. Everyone (inaudible) on that meeting schedule (inaudible).

Mr VASHIST: Brilliant.

Mr YOUNG: We are meeting with aged care after lunch.

Mr VASHIST: I do not want to take that away from them. They have their opinions and they will share that firsthand with you.

Moving the focus outside of Tennant Creek, looking at our communities—in our communities, for example, in Epenarra we do not have an aged-care facility and we have elders there. When we focus on southern Barkly communities we have got to have a holistic approach in supporting our people in those communities. That approach would be, when you talk about Arlparra, Arlparra facilitates a population that is transient for up to 1,300 people. That includes the entire Alyawarr(?) region, so you are talking about Ampilatwatja, Arlparra and Alpurrurulam and emphasis on the 17 homelands that surround Arlparra. There are a lot of elderly people in these homelands who do not have the access or the knowledge, know-how or support to reach to the nearest communities and get what they need.

Urapuntja health corporation are trying their best, but they are under-resourced. This is where the emphasis is resourcing the aged-care sector, providing more infrastructure upgrades in some of our communities. The emphasis being Epenarra does not have one and in the southern Barkly region in the Utopia(?) homelands we need to strengthen the Urapuntja Health Centre to facilitate more conversation around aged care and palliative care.

Mr CHAIR: Can you tell us a bit about the palliative care specifically? What have you got functioning in Tennant Creek in and around …

Mr VASHIST: NT Health is looking after that. They move people on along at the aged-care sector and they will talk to you more about that in that space. I think NT Health was on your list as well.

Mr CHAIR: We have spoken to a number of people in a number of places, including NT Health from the top down …

Mr VASHIST: In the Barkly here?

Mr CHAIR: Today—are we speaking to anyone from …

Unidentified speaker: We are speaking to the hospital tomorrow.

Mr CHAIR: Yes, the hospital tomorrow; sorry.

Mr VASHIST: Tanzil, in the hospital these guys will actually give you a better picture and more up-to-date information. There are programs and support that is coming their way, but we have to get the timing as a matter of priority to be done as soon as possible because this is something for us.

Our frustrations in Tennant Creek—the councillors will agree here as well—are our projects, from a good idea from transition into delivery, can take six to eight years. That is the reality here for us. That is a reality we are very willing to change, and support the government. We want to support you guys in your deliberations and we want to support the Australian Government as well, because fast-tracking the projects, service delivery and the important infrastructure that is needed—even for the hospital in this instance—is very much required. We do not have that, but we have the ideas and pathways that we are going to get it. The question is when are we going to get it. This remains our challenge.

Mr CHAIR: We should be clear that our remit is to specifically look at that and write a report in that ballpark, but we would be remiss in our job if we were blind to all the issues around it that interact with VAD, which is why we ask about aged care, palliative care, the hospital system et cetera et cetera, because they are all part of a system.

We want to focus a little on VAD specifically in a bit. Before I do, though, I will pass to Dheran.

Mr YOUNG: I want to go back to where you talked about a couple of communities. Was that in the Utopia homelands region?

Mr VASHIST: Yes.

Mr YOUNG: There are no aged-care facilities out there at all?

Mr VASHIST: Council is funded to have a position for aged-care worker based out of Arlparra. This aged care is providing meals and driving to the homelands. I think that is restricted to that.

Mr YOUNG: It is really just a Meals on Wheels program …

Mr VASHIST: Yes, that is the home care packages.

Mr YOUNG: But no actual physical spot for …

Mr VASHIST: That region has always been shared between Alice Springs and Barkly. Then when you talk about NDIS and all the other stuff, which I do not want to get into too much detail, the service providers are always jumping in from Alice or from the Barkly, and there is no communication. The information sharing is not there and things get lost.

Mr CHAIR: Two things here. One, Pennie, I am mindful that it might be helpful for us to explain some—Pennie can you hear us?

Ms COWIN: Yes.

Mr CHAIR: I will step through the model for what has been proposed with VAD in this report in a tick, just because it may be very useful information for you, looking for that granular detail. I also saw Councillor Marlow nodding along and wanting to say a few things about service deficits, if you like, in aged care and all that. I am really keen to hear about both of those things.

Before I forget, shall we go to you, Greg? Do you want to chip in? I saw you vigorously nodding and about to say things a few times.

Mr MARLOW: I was going to interrupt the mayor, but, Chair, are you receiving a submission or are you going across the road to Pulkapulkka Kari …

Mr CHAIR: We are, yes.

Mr MARLOW: … to listen to what their concerns are?

Mr CHAIR: Yes, later today.

Mr MARLOW: They have got a number of beds. If they expanded, that would give locals the option of staying in country or in town, rather than relocating to larger centres like Alice Springs for palliative care or, alternatively, using the hospital facilities, which, again, uses up hospital beds which should be for medical reasons not for palliative reasons.

Mr CHAIR: You are right about that.

More broadly speaking, people out in community have been extremely generous with us in sharing their thoughts and feelings on these issues, noting it is a sensitive matter to discuss. What we sort of consistently hear is the sentiment of maybe VAD legislation is not for us; however, we do not necessarily mind if other people have it. But then the conversation broadens to this idea of people wanting more help and choice to finish up. In particular, that means being able come back to country a lot of the time.

That is something we would like to hear a bit about from you guys as representatives of the council as well. We know that, for example, there are people who end up stuck in an urban centre, whether it is Darwin, Katherine or Alice, because that is where the services are primarily available. If we have an understanding of how readily or regularly people are able to come home to country, particularly when they are extremely ill, terminally ill, palliative, that is useful to know as well. Any anecdotal stories you can share about that or any idea that you have generally about whether—I mean, are people prohibited from being able to come here at the moment because of the lack of space? Is that the suggestion—or the lack of service?

Mr MARLOW: I guess it would be the lack of associated services, the people on the ground to be able to go and visit those patients—or clients is probably a better description. In some cases they are in bed in the hospital. In some cases they are in bed at home. There is only a certain number, very few, providers that actually go on a daily basis and see how these people are progressing, how they are surviving through another day.

Mr CHAIR: Again, I am very mindful that we do not want to come and promise the Earth and say we are going to build a new hospital in Tennant Creek; that is outside of our remit. But it is …

Mr VASHIST: It is on the list, though!

Mr CHAIR: It is on the list, I am sure—no doubt.

Mrs CARLSON: But maybe we need to ask the question: how is someone who has a terminal illness supported in this community? What support services are there for them?

Mr MARLOW: If they have got family that is fine, but they are still going to need some medical support. Those who are individuals, such as myself, if I was terminally ill, then where is my network? I would probably be visiting the hospital on a daily basis just to get an update so they can check on me to see how I am going.

Mr CHAIR: Just one thing quickly, you guys have all been representatives in one form or another for this community for a period of time. Has the situation, broadly speaking, improved or gotten worse over the last five years, 10 years, decades? We know the health services provision has changed from time to time in some communities. In some places it is actually better; other places they used to have a nurse there all the time and now they do not and so on and so forth. Generally speaking, how are things trending?

Mr MARLOW: In town it has not changed.

Mr CHAIR: It has not changed; okay.

Mrs CARLSON: But in the remote areas you were mentioning?

Mr MARLOW: It certainly has not improved.

Mr CHAIR: So, it has been in a sort of stagnant situation for a period of time. Was there ever a time when you had a critical mass of doctors and nurses here in terms of primary healthcare that made that more accessible, let alone palliative care?

Ms COWIN: Was it, Greg, when the mines were more active here?

Mr CHAIR: Okay, yes.

Mr MARLOW: I mean that is back in the 1990s, so there you go; that is 30 years ago. The other aspect is that we are all 30 years older and we are all closer to death. That is why it actually has not changed. I cannot see that it has actually changed. It has not improved; I do not think it has got any better than it was before. As I said earlier, if Pulkapulkka Kari, as an example, expanded with another 10 beds, that would take the pressure off the hospital.

Mr CHAIR: Yes, we understand that.

Matt, do you have a question?

Mr KERLE: Yes, it is just about generally old people and healthcare. You may not know; if you do not know that is fine. Say someone had a terminal illness and they were at home, are there any nurses that can go and visit them at home or is it only provided out of the hospital?

Mr MARLOW: There is for Aboriginal people, but there is not for non-Indigenous people. If you are in the capital city, you have blue angels or whatever you call them; these are dedicated services that do home visits. We do not have that in Tennant Creek. We do for Aboriginals, but we do not for non-Indigenous.

Mr VASHIST: If I may, Tanzil, Councillor Marlow just flagged a very important point—ACCHOs. The framework since the introduction of ACCHOs—Anyinginyi Health Aboriginal Corporation, one of the first ones that came into existence. Danila Dilba and these guys actually came in since the establishment of ACCHOs and the framework behind them. They have done their best with what they have got to support the Indigenous people.

When it comes to home visits, that is something that is not provided to non-Indigenous people here. That is what I am hearing. This is something that is needed as well. Some people do not wish to be in the hospital and want to stay at home. That option, if that is facilitated, will be very much appreciated by a lot of people here. ACCHOs do a very good job and ACCHOs continue to get better, even in the communities.

Oly Carlson asked a question: what about communities? In communities Aboriginal health corporations are gaining strength and they are getting the support. With the recent introduction of good ideas with the APO NT, with the introduction of additional funding, I think we are heading in the right way. What is immediately available now is still something that—the gap still exists.

It is not related, but I mentioned renal before. The dialysis remains a major issue. Renal failure remains a major issue …

Mr CHAIR: It is very relevant.

Mr VASHIST: … with Indigenous Australians in the Barkly. I have calls received from Elliott. I received a call from Ali Curung. We have had people who have moved to Alice Springs who are calling me in tears, ‘I want to go back home. I would much rather just say goodbye to this world at home.’ That is the kind of sentiment. We obviously direct them to the support they need and get them to touch base with the Health department again.

Dialysis has a major implication on the thought processes of people who are potentially—some individuals might be walking on country and perishing. That remains a concern here.

Mr CHAIR: We know that renal issues are high on the list of health challenges for all of the remote areas. The availability, or lack thereof, of dialysis everywhere makes those choices really difficult, definitely.

Generally speaking, we are talking about people with renal issues, cancer, neurological conditions when we are talking about the VAD space and the palliative care space.

It is interesting. We have not heard somebody say, like you have before, that you have had people directly ringing to say, ‘I have had enough of dialysis; I want to go back to country.’

Mr VASHIST: It is an individual who is extremely frustrated, calling, ‘I want to be home. I do not want to be in Alice Springs; I want dialysis provided to me in Elliott.’

Mr CHAIR: It is not a case of, 'I want to withdraw and die out in Elliott'; it is 'I want to go back to Elliott where I would want the dialysis to be available'. Is that correct?

Mr VASHIST: Yes, absolutely. There has been a case where a Tennant Creek resident decided not to take renal anymore.

Mr CHAIR: Okay, so to actively withdraw from care?

Mr VASHIST: Active withdrawal from care because they did not see—whatever the reasons were, without going into too much details; I need to keep that confidential for the individual …

Mr CHAIR: Sure.

Mr VASHIST: An Indigenous elder of this community chose that. I think those conversations will be brought up to you guys in writing.

Mr CHAIR: Yes, we have heard those kind of conversations elsewhere, where people would like more help and choice to finish up. That is the sort of phrase that we find resonates strongly.

Mr VASHIST: I think you have worded that a lot better than I would.

Mr CHAIR: We stumbled on it by accident, believe me. We did not choose the words 'voluntary assisted dying'. A lot of people do not like V-A-D or 'VAD' either. They do not want to hear either of those words. Some people remember fondly—Councillor Marlow, you will remember 'rights of the terminally ill' or 'euthanasia' resonate strongly for some people still. But these are the words that we are tasked with using. In terms of the communication we have also been working with very good interpreters everywhere we have been. We find that when we talk about help and choice to finish up, we get a lot more nodding heads.

It is interesting to hear the testimony about when people choose to actively withdraw from care and come back to country and about when people also say, 'I am fed up with being in an urban setting and I would like to come back. I wish there was more help available for us.'

Mr VASHIST: Yes.

Mr CHAIR: Can you tell us, any of the rest of you, do you have any more knowledge of stories or instances like that, anecdotally or otherwise? Pennie? Greg? Go ahead.

Mr HOLBROK: It started off with palliative care and medical services. Kidney function is entirely different. In general, there is very little home service here in Tennant Creek. My wife is getting a nurse coming every morning to dress her leg which needs treatment, but she is one of few who do home services.

The biggest problem is to get competent people here and for them to stay here. It does not just go for nurses; it goes for a lot of people here in Tennant Creek. We used to have a resident doctor here many years ago, Dr Tonga. We also had a resident dentist. It has been changed. We now have doctors coming here on a six-month basis. You will get a good doctor and you will get a bad doctor. You finally connect with a doctor you can talk to, and they go somewhere else. We have got plenty of doctors here. It is easy to get into the GP clinic, but the thing is to get a doctor who will listen to the patient. That is the problem. It is great you get them coming in all the time, but they do not stay.

I can give you one example. I went up for a blood test and the nurse spoke with an Irish accent. I said, 'Are you are from Ireland?' She said, 'Yes'. This was in the middle of summer here, 44 degrees. She had just arrived from Ireland one month earlier and she was gasping. This is the type of thing that happens. They send people like that up here who are not fit to be here. It is just a humorous thing.

But the thing is palliative care is, for want of a better word, non-existent here in Tennant Creek …

Mr CHAIR: Right; non-existent—gotcha.

Mr HOLBROK: It is extremely minimal. If you go to the hospital, they are great at the hospital. They will look after you. I would much rather have this hospital here than Alice Springs. Alice Springs is chop, chop, chop, chop—next one on the assembly line. Here they look after you. They have got time to talk to you and they are good, but they are not more than a glorified first-aid box. If it is a broken arm or anything—Alice Springs.

Mr CHAIR: Yes. On that issue—that is really invaluable information—I take your observation about the care here being well-meaning and high quality, but limited perhaps in what they can do for you.

Mr HOLBROK: Yes.

Mr CHAIR: Can you give us any sense, from your years over here, about the availability of specialist doctors or the nursing staff in Tennant Creek and across the Barkly?

Mrs CARLSON: Pennie is shaking her head.

Mr CHAIR: Pennie, why do you not chip in on that for us?

Ms COWIN: I go to Adelaide every six months to see my specialist and then I go to Melbourne every three months to have specialist treatment because it is not available in the NT. I have been doing this now for six years.

Mr CHAIR: Pennie, without wanting to put you in an awkward position, can I just ask what specialist you are seeking the services of, like just a general college?

Ms COWIN: I have got bowel cancer from Crohn's. That got out of control during COVID—we all know what happened then. The only specialist that can deal with the removal of it is in Melbourne.

Mr CHAIR: Gotcha, yes.

We know that not all specialists are, obviously, even available in Darwin, let alone subspecialists in oncology, so it is very challenging in that space. But in Tennant from your …

Ms COWIN: Also, this is at my cost too. I do not fall under PATS.

Mr CHAIR: Yes, I understand.

Ms COWIN: Because I go to Melbourne I do not fall under the NT PATS system.

Mr CHAIR: Patient Assisted Travel Scheme we are talking about, yes?

Ms COWIN: Yes.

Mr CHAIR: I am just putting it on the record.

Mr VASHIST: Pennie, if you wish, you can request your diagnosis to remain confidential.

Ms COWIN: No, I am okay. I am very vocal about it; do not worry.

Mr CHAIR: On the issue about being vocal about it as well, Pennie, I know that you work in a pharmacy. Can you give us any sense of whether you have any initial idea or reservations about the handling of, for example, substances, let alone that might also include in the future VAD substances? Would there be the capacity to do that here? Would you have any concerns about it?

Ms COWIN: I think that is out of my purview to say because we are part of a conglomerate.

Mr CHAIR: I understand what you are saying.

That is a useful note for me to point out the model that is being proposed in this report, which is broadly how everyone in Australia, give or take, does things. I am just going to walk that through for everyone, so then we might actually talk about the VAD thing specifically.

On page 62 of this document here, there is a flowchart, if you like, which pretty much steps out in broad terms four stages. If somebody is terminally ill, over 18 and fully cognisant—not with dementia and able to make their own decisions—they can go to a medical practitioner who is fully licensed to practise independently, whether they are a GP or a consultant neuro. Then if they can convince that person that they are a candidate for VAD, after a waiting period they can progress to a second stage, which is to consult with a second doctor.

The second doctor in some places has to have specialty in the thing that you are suffering from; in some places it can be something more general. That varies a little bit. You basically have to convince two separate medical people that you are a proper candidate for VAD.

Then after a waiting period again, which in most places is around nine days—but in some places it is five days—then there is a third stage where you have to provide written consent with a couple of witnesses. The witnesses cannot be people who are beneficiaries of your will or that sort of thing; they have to be independent witnesses. Again, that varies a little bit from place to place.

If you can satisfy all of that, then the final stage involves a team of medical professionals, which will always include a doctor just about, but sometimes will include nurse practitioners or ENs or RNs who will help with the administration of a substance. That substance can be administered by that team or a person can elect to self-administer, supervises or unsupervised in some place as well, with the help of a contact person. That is roughly the way it works.

In other places where there are more options for where to store things, for example, substances can be taken out, kept by a contact person, stored in third-party pharmacies and/or premises under locked boxes and whatnot. The suggestion in this report for the Northern Territory would be that almost all of those kind of things would be centrally administered and kept separate and away from places like communities and regional centres.

In essence, what this model has been proposing is to use that same flowchart, but because we know that the uptake of this will probably be less than 20 people a year, if and when it ever happens, it would not be necessarily that every centre would have VAD specialist people. It would be a case of if you manage to get through those threshold criteria probably only at that last stage would you have somebody who would come to you, wherever you were, to help with the process.

The idea is that we would be able to help people pass away at home, in a nursing home or—outside of a hospital setting is the general idea.

That is the broad model that is proposed. Do you have any questions about that, that we might be able to knock on the head for you? There is a lot of fine-grain detail, of course.

Ms COWIN: I suppose we are asking for any safeguards that need to be put in place.

Mr VASHIST: I am certain …

Ms COWIN: Say in a place like us, here in Tennant Creek, where we are the only pharmacy and we supply multiple community clinics, what safeguard would there be if we did hand something over and then someone in the family objected and it went to court and things like that, what protection would we have or the clinic have for the supply of that product?

Mr CHAIR: These things would be—to be honest, all of these details are not fully fleshed out in this model for how it would work in the Northern Territory. But the suggestion is, broadly speaking, that I am presuming your pharmacy would handle all sorts of sensitive medications, all sorts of, obviously, pain relief and high-end pain relief that could also be dangerous in the wrong hands.

The whole point is for a VAD substance that was specifically being used for a VAD process, it would pretty much be coming in on demand and more or less under lock and key until it was in the right hands to be utilised. I think we would assume that other than in the minimal transit time in a local point where something might need to be kept refrigerated under lock and key, it would not get into the wrong hands.

Having said that, in all other models to allow people to self-administer there is a process for appointing a contact person. You appoint a contact person and then that contact person is essentially authorised to be able to pick up the medication, supply the medication, return the medication at the end of it. That is generally how that process is meant to work. Whether that would work as seamlessly or efficiently in the Northern Territory, given all the distances and limitations, we do not know. To be honest, that is a question that is going to be a down-the-track implementation question for the Health department and/or the review board that would have oversight of this.

In terms of all of this, there is meant to be, if you like, a review board that governs the process and sort of helps adjudicate appeals and keeps oversight of the whole thing. Again, what the composition of that review board would be, who would head it up, where it would be located—whether it is in the Health department or

separate from the Health department—these are things that there are not definite answers for. We are starting to form a little bit of a view ourselves having heard what we have heard about how that might work, and the key thing for us is I think we realise that we want to make sure if VAD is available, that it is available in a safe manner and that things do not get out in the wrong places where they should not be.

Ms COWIN: I would hate to see anybody end up after the fact in a legal argument because somebody else has taken offence to somebody doing this.

Mr CHAIR: Look, Pennie, to give you some confidence, VAD has been running in all other states and territories relatively smoothly for a number of years now. There has been the odd occasion where something like that has gone pear-shaped and then there has had to be a look into that, an inquiry and proceeding after the fact, but we are talking about very small numbers of that and hundreds and hundreds of people across the country who have successfully taken avail of this. About 4,000 people across the country have used it in different places.

Victoria started this process first in 2017, and the uptake there is between 400 and 500 people a year fairly consistently at the moment. That is not to say that it has been perfectly seamless everywhere of course, but the other thing is that there is an 18-month implementation period after legislation gets passed.

Just to be clear again, we are not drafting a Bill; we are providing a report to the parliament. The parliament will determine whether they want to draft a Bill or not. We have been asked to provide drafting instructions for that Bill if we think that a Bill is worthwhile. It is more than likely that we will provide a report and some drafting instructions, but then it is really in the hands of the government to decide whether or not they want to make a Bill. Then the Bill still has to pass. Then after that you have got 18 months before anyone in the real world could access this.

We are still a ways away. Let us call that two years optimistically if anything was going to happen. That is two years' worth of time for everybody who is interested in this to also plead their case in relation to how this fits in with the rest of the health system—aged care, pharmacy, palliative care. That is why we are discussing these issues as well because one other thing that is clear is that throughout the country wherever they have introduced a VAD law, the need for palliative care services seems to go through the roof as well. That is not surprising entirely because now that you are offering a VAD service, whether it is completely separate or part of the health system or not, either way a lot of people want more options on end-of-life care before they start thinking about the VAD service as well. It is sort of like a security blanket for a lot of people in that regard.

Does that make sense?

Ms COWIN: Yes, that does.

Mr MARLOW: What is to stop an individual in the Northern Territory relocating to another state to use their legislation to go forward?

Mr CHAIR: Nothing can stop them doing that, but there are minimum residency requirements that vary slightly from state to state. The idea is to prohibit forum shopping—you just turn up and you can use it willy-nilly as it were. All states have a residency requirement; that is right, isn't it?

Unidentified speaker: Yes.

Mr CHAIR: All states now have a residency requirement. All states have an operational model except for the ACT. The ACT has passed law, but that law is still within that 18-month implementation period. At the end of this year it will go live, as it were.

In the Northern Territory there are also suggestions within this report that there should be residency requirements, albeit they are a lot more flexible in here because part of what they suggest is that people who have a genuine commitment or connection to the NT, or a cultural connection to the NT, who may have had to be out of the NT for a number of years for whatever reason should still be able to avail themselves of the service here.

Those kind of curly questions on eligibility would be the kind of thing you would expect to go to a review board, probably. Let us say I had an illness, could not get treated here, was away for a number of years but would like to come back and pass in the Northern Territory—if you qualified under the other aspects of the legislation or the process, you could speak with the review board and say, 'I should be able to do this here because I am attached to Larrakia country' or Arrernte country or whatever it might be.

Mr MARLOW: So, two things out of that. One is using me as an example, I have a rental property on the Gold Coast in Queensland. What would stop me going to Queensland and partaking of their legislation?

Mr CHAIR: Nothing specifically. I cannot remember the residency requirements for Queensland. Everything is slightly different everywhere. I would not want to give you false information. I think in principle we could say nothing.

Mrs CARLSON: In principle some people are thinking about it now who have recently been diagnosed. Because it is not legislated in the Northern Territory they are already starting to make those transition requirements in another state as well, which means they are not dying where they want to die.

Mr MARLOW: The second point is what you raised just then in that we have got a nomadic or transient population. People move from community to community to community at various times of the year. As an example, they might not be at Alpurrurulam for 12 months. Because of the Wet Season they move to Mount Isa, Tennant Creek or Alice Springs. That is where you are saying you have got to have some flexibility in your legislation to take account of that.

Mr CHAIR: That is right. The key thing that comes of this is that we know that the uptake of VAD in the Northern Territory—if it was to be legislated—would likely be only a couple of dozen people or less. We also, except for Queensland—I think we will come back to this.

We also know that the uptake within Indigenous communities would probably be even lower within that space. However, the whole point of this committee's process is to make sure there is equity of access so that if somebody was terminally ill, suffering and had chosen and wanted a voluntary assisted death that we could help them at least, as opposed to simply saying, 'This is only available in a hospital in Darwin'.

That is what we have got in our mind. We know, though, that there is a very small number of people who might choose for this situation, so the challenge for us, as a committee, as well is to think with our practical hats on. We would like to see people have this opportunity—as you pointed out—people had 30 years ago. We also know there are other capacity deficits in the healthcare system. Adding a new thing on, as the Health department tells us, takes extra time, people and money. We have to work out what we can practically recommend that is a smart way forward as well.

At the moment, we are lucky in the sense that this committee is not starting from a standing start. This expert report took a lot longer than ours did to think through these issues. It is not the only report either; we have had lots of conversations about euthanasia and voluntary assisted dying over a number of years in Australia. We are not reinventing the wheel here; we are trying to add some value to the existing stuff and particularly learn how people feel about it out bush.

We have been learning a lot. Everywhere we have gone we heard things from you guys, and it has been really instructive.

Greg, you wanted to say something?

Mr MARLOW: Two more points. Firstly, in Australia we had the first legislation. It was basically blocked and taken out of the way. Every other state has put in place their legislation. It is now our second attempt. We can learn from inconsistencies or best practice or whatever in every other state to create a better law within the Northern Territory. That is the first point.

The second point is that the key word is 'voluntary'. It is a voluntary option for a patient or client to consider. It is not compulsory; it is just an additional option of how an individual wants to be medically treated.

Mr CHAIR: Yes. We very much spoke to both of your points—actually I just want to come back to the Queensland residency situation that you raised.

We are at great pains to always emphasise 'voluntary' and 'choice', particularly out bush. That has been very helpful as well when people are clear that nothing is being mandated, nobody has to be forced to do anything; It is just a case of, 'Would you like this choice?' and, likewise, 'If other people have this choice, would that offend or upset you, are you okay with that?' That is the first thing.

To your first point—just remind me, Greg, what was the first point you just made then? It was important and I wanted to touch on that. You were talking about choice first and just prior to that you mentioned something else.

Mr MARLOW: Choice was second. The first point was in relation to best practice.

Mr CHAIR: Yes, of course.

You are absolutely right. We have the benefit of knowing what every other state and territory has done. We also have the benefit of a report to work as a baseline. We also have the benefit of a specialist advisory team, based out of Queensland, who have helped other jurisdictions provide drafting instructions. We are trying to learn, but as everybody in this room knows better than probably all of those people, the Northern Territory is different. Geographically, demographically, 30% of the population being Indigenous, the health burden of disease situation is different here than it is anywhere else. That is why we are trying to make sure that whatever law we pass is not just a cookie-cutter version of what happened somewhere else, but then is not very implementable in the Northern Territory. If we just pass one of the early versions of these laws from another state, we might have a lot of challenges in people outside of Darwin being able to access any help. That is why we are thinking through that. We appreciate you reiterating the point. We are certainly trying to be mindful of what happens in other jurisdictions.

One of the things that I will say in relation to the Queensland point you raised—Queensland is one of the earlier adopters of this and they now also have a review board.

I am just waiting for that plane to pass, just in case you cannot hear me. There is a lot of traffic at the airport today.

Mr VASHIST: There is an air race on.

Mr CHAIR: Air race, of course.

Mr MARLOW: There probably will be a lot of air traffic.

Mr CHAIR: Yes, literally it was like New York City, landing here today.

Queensland has a review board that has already started looking at how their VAD law is working. They have already had a look at the residency exemption situations. The situation you were raising before, what I can tell you is that Queensland's residency requirement is that somebody has to be ordinarily resident in Queensland for at least 12 months immediately before they make that first request. However, if you do not meet that residency requirement, you can apply to Queensland Health, their health department, for an exemption if you can demonstrate that you have a substantial connection to Queensland or where there are compassionate grounds.

So far, 26 exemptions have been granted in that regard in Queensland between 1 July 2023 and 30 June 2024, so in that first year. A small number of those, less than five, were exemptions that were granted to people who are outside of Queensland, mostly on the Queensland–New South Wales border. That is sort of what has happened. In all those stages, regardless of the place of residence, all the steps in the VAD process were completed in Queensland.

Every state and territory has got a version of this. Only a couple of them at the moment have got review boards that are actively going through, checking how things are going and fine-tuning it.

There is sort of now what people broadly refer to as an Australian VAD model, which is a lot more detailed than what happened back in 1995. The original *Rights of the Terminally Ill Act* that you recall, was a pretty straightforward process, but there were not many checks and balances in it. Now there are more checks and balances in the Australian model which does make it a little bit more cumbersome than just finding someone to sign off and then it being decriminalised for a doctor's purposes, but it is the model that everyone sort of broadly is agreeing on.

One of the things all of Australia does not do is allow somebody with dementia to access voluntary assisted dying. You have got to be able to give consent. You cannot specify in an advance personal plan, 'Even if I get dementia later, I would like to be a candidate for this'. In Australia, that is currently a no-go.

In some other countries it is still possible. There are much more permissive laws on voluntary assisted dying in a number of places across the world, notably in the Netherlands and in Switzerland. The Australian model is pretty consistent, so we as a committee are unlikely to recommend that we do what happens in Switzerland, put it that way—right? We are probably going to try and stay pretty close to what is recommended here, but we still need to figure out how do we make this work in the NT, given geography, demography, a high prevalence of renal incidence et cetera et cetera. That is kind of where we are wrestling with all of that.

Mr VASHIST: If I can make a quick comment, on the service model with the self-administration, I just want to share our lived experiences in the Barkly—right?

Mr CHAIR: Yes, that would be great.

Mr VASHIST: I want to correlate that to the dialysis and renal again. What has not worked in the Barkly has been the active promotion of self-care dialysis at home.

Mr CHAIR: That is a very good point.

Mr VASHIST: The self-care dialysis is something that has not worked because of a multitude of reasons, whether it is the hygiene—availability of a clean home or a bed. It could be a multitude of reasons behind that. Having said that, this is where I feel a bit anxious and nervous when people talk about self-administration and VAD. When you give the statistics 30% of the Northern Territory is Indigenous, in the Barkly 70% is; the statistics are just opposite. We have to represent the people and be mindful of that. It is going to impact our regions a lot more. Voluntary, people may choose or not choose to do it, but having said that, with the self-administration side, would that be considered in collaboration with ACCHOs and promotion of AHPs involved in that?

Mr CHAIR: It is a very good point, one we have been wrestling with. In some places, self-administration still has to be practitioner supervised. Even if you have chosen a self-administration path, a registered healthcare person, which is usually a doctor, but in some places it could be a nurse practitioner—that sort of thing—has to at least supervise it. In other places, the suggestion is that does not need to be the standard. What is your view on that issue?

Mr VASHIST: My view, personally, not council, for the record—and this is having lived and witnessed the self-dialysis and the failure of self-dialysis in the Barkly, where people are not using that—they would much rather be in renal facilities or go and have a self-dialysis bed available in a health clinic that is locally available. People feel nervous. Even when you actually educate and have a support worker that has been educated within the family group to actually cater that, people are still very nervous in doing it. Things can go terribly wrong. I have known instances where things have gone wrong in that space and people have had to use RFD and fly out of these communities. For me, personally, self-administration is something that needs to be done hand in hand, mandated, if it is our communities by ACCHOs and the introduction of Aboriginal health practitioners.

Mr CHAIR: That is good to know and to have clarity about that.

With some of the service providers you are mentioning—again, you guys will all know this; I am not telling you anything you do not know—some of it is the Health department obviously; some of it is third-party organisations who are providing services on the ground, most of which are in receipt of a government grant to provide that service. We cannot at the moment mandate in any way what a third-party provider would do.

What exists in other parts of the country is a review board and sort of an accreditation scheme so that whether it is medical practitioners or organisations, they can essentially opt into a system to be accredited providers of some part of the VAD process. Or they could just choose to be not part of it because there are medical practitioners and nurses, for example, including organisations as well, who actively do not want to have a part in VAD, for various reasons. Some of them might be for personal reasons, cultural reasons, but some of them might also be a specific palliative care provider who does not also want to be in the business of VAD provision because they do not want to blur the lines, so they may choose to not have a part of it.

What we are probably starting to realise is that we also have a network of people who are government health providers, as well as a network of people who are private healthcare providers, including community organisations, the likes of which you mentioned. We would like all of those people to have the opportunity to be able to opt in to help with this service if they want, but, equally, to be able to say, ‘We do not want to be part of this; our core business is elsewhere.’ That is sort of the rough direction we are thinking about. We have not finalised anything. How does that sound to you?

Mr VASHIST: That is great. If there is an opportunity for them to come on board and have the choice to work, it is definitely something that I think will be a bit more well received by the members of the communities, whether it is Ali Curung or Ampilatwatja. People will have a choice.

Mr CHAIR: The same thing with voluntary here, it is not just voluntary in terms of choice for a dying patient to choose; it is also that we do not want anyone in the system to be forced to have to be a part of this if they do not want to be a part of this. Early days, for example, in Victoria when they started this, medical practitioners were not allowed to initiate conversations about VAD. There was like a gag on them which was very difficult for people to manage. Now the suggestion in this report, and across most of the country, is that medical professionals should be able to talk to a terminally ill patient about all the options, including VAD, provided they also talk about palliative care, aged care and any other option as well.

We are trying to provide choice for everybody, whether or not you want to choose to be part of the system, choose it for yourself, choose to withdraw from the process as well. We do understand that at the end of the day it is not the Health department itself that provides all the health services across the Northern Territory; it is a network of providers, all of whom are doing their best to work together. We do not want anybody to be excluded from that process or forced into that process.

Greg, does that sound about right to you as well?

Mr MARLOW: Yes, I am just thinking that you are right, it is not only the patients or the clients who are putting their hand up saying, 'I want it'; it is also the practitioners who actually have to administer it or supervise it. There will be some in the medical profession, whether they are doctors or nurses, who say, 'I do not want a part of that'. Again, this is probably why you need a second or a third opinion on, 'Yes, I am available to help you out'.

Another observation or a comment would be when you are in the last stages of life, you probably want somebody that is a family member or somebody you trust around you. If that is going to be a visiting practitioner from Darwin, for instance, that might not be the best person. Yes, they are qualified to do the administering of the drug, but you would probably be happier or calmer to have the family doctor or the clinic nurse around. As I said, in your last stages of life you probably want people around you who are familiar with you, who actually care about you.

Mr CHAIR: You are right. We hear that a lot. In Indigenous and community settings we particularly hear about the importance of having an extended range of family and kin around you. But it is no different for anybody; people do want to, generally speaking, have other loved ones around them at a time of their passing. Again, this is about providing people that choice to choose where they might pass, if they require assistance and an assisted death.

Sid, one thing I should clarify that is very important that I neglected to mention was on the self-administration front that is ordinarily done using the oral ingestion of a substance, not necessarily something done intravenously. Again, the fine-grain detail can vary from place to place, but, generally speaking, self-administration involves ingesting a substance orally, as opposed to self-administering a needle, as it were. That changes up slightly what you were saying. Irrespective, we understand the concerns that you are making.

The broader question for us is one of whether or not somebody should be there to supervise, even if they are not administering, whether they are proximate to the process. The idea is, of course, you do not want to impose a burden on somebody, like if somebody does not want an unfamiliar person in the room, then that is the idea of not having a practitioner having to have oversight. But, in terms of safe storage, sometimes—go ahead.

Mr VASHIST: Tanzil, thank you for clearing that up. This is best fitting for Councillor Cowin, with a different hat on as a pharmacist. The number of times where the tablets go here or there, things can be going missing. That is why the introduction of Monday, Tuesday customised packing that the pharmacist provides to support our mob in the communities …

Mr CHAIR: Yes, we understand.

Mr VASHIST: … to make sure that this is the right medication.

Oral medication, yes, it is a lot better than the injection. This is where I am still feeling, personally, very nervous because we know, having lived here, that wrong medication can be taken sometimes.

Pennie, would you like to add something to that at all?

Ms COWIN: Obviously, we put in checks and balances here as a pharmacy, but this is where there definitely needs to be a lot of remote control over all of this. It is not so much—I do not think it is deliberate; I think it is misunderstanding …

Mr VASHIST: Absolutely; it is important to emphasise that.

Ms COWIN: A complete misunderstanding.

Mr HOLBROK: It is more on the technical point of view with the legislation. When we had the VAD introduced in the 1980s it was taken over by the federal government by using a law which was ambiguous, for want of a better word. It is so easy with VAD legislation that it can be used wrongly because it is not written correctly. It is so easy to put a mistake clause into a law. Really what we are looking at here is to get something which is watertight, if it is possible, in legislation because people who want people to be with them or not be with them should not be subject to misinterpretation of the of the law, which can be so easily misused. We have one with that (inaudible) in America. He is using the law the wrong way. We do not want this to happen here, regardless.

Mr CHAIR: You are certainly preaching to the choir. I am the one person who, more than anybody, wants to make sure that this—we all do as a group—law is well thought through, if it ever gets to that stage, and that we do not inadvertently rush it, make mistakes or miss things.

We are lucky that we have a specialist advisory team based out at Queensland University of Technology who have advised other people around the country on this. They will, hopefully, help us make sure that whatever drafting instructions we might provide are sufficiently detailed to cover all of the scenarios as best we can.

If we were at the stage of providing in our report instructions to the government—let us say, as a metaphor, we recommend you bake a cake. We are not just going to say we recommend you bake a cake; we will say exactly what type of cake it is, what all the ingredients should be, exactly how you make it and what oven you should bake it in if we can. We are trying to provide as much detail in the drafting instructions and our report as possible within the time that we have available to us to do this work.

We have covered a lot of the Territory in the last month, but it was not possible to cover the entire Territory. We are learning more everywhere we go.

Our undertaking to you, sir, certainly is to try to make sure that our report and drafting instructions are as comprehensive, detailed and thought through as they can be. Then we hope that the government will be well guided.

Mr HOLBROK: Also, it involves the person, the medical provider, who will be assisting in the VAD?

Mr CHAIR: Absolutely.

Mr HOLBROK: If the doctor does not want to get involved, there should be an out for them.

Mr CHAIR: Yes.

Mr HOLBROK: It should be voluntary for them as well, because I would not like to do it.

Mr CHAIR: No.

Mr HOLBROK: There are people who are mentally competent to do this sort of thing. There has got to be an escape for the medical staff involved, which I think is important.

Mr CHAIR: There are about 1,400 doctors in the Northern Territory and the whole point is we would not expect all of them to be involved in this, but we want to provide the opportunity if it goes forward for whoever does want to be involved to be able to be involved. That may be a way forward, rather than forcing just the Health department or just private providers to be able to provide the service, let alone telling third-party

providers, whether they are an Aboriginal health organisation or whether they are even an interpreter, that you have to be part of this.

We have heard from an interpreter or two. For example, we had an interpreter say to us that they would not feel comfortable having to have these discussions about voluntary assisted dying with their community, so it goes down to that level as well. We know how important it is to have good communication and how important it is to have interpreters to be able to speak to people in remote areas, but there also needs to be an option for those people to opt in or out of the system.

Mr HOLBROK: (inaudible) to their family. I have seen it; I worked in various communities. They will agree with you and your opinion, but when it comes to meeting with their community, they go totally 180 degrees; they agree with them after they have agreed with your submission. So, they are very much subject to family pressure and that is one danger. If the family says, 'No, we don't want you anymore', they can put the pressure on the person. I do not know how you are going to put that in …

Mr VASHIST: Just on that, Len, misinformation and disinformation can be easily—that is the part that you want to actually convey. Tackling that misinformation and disinformation around VAD is the key when you are working with the First Nations people.

Mr CHAIR: Our report will emphasise, at great length of course, the importance of communication back out to communities and the rest of the Territory generally on what is going on. We at the moment are in charge of our own communication while we are a committee until we provide a report, but after that it becomes a question for the government to communicate with the Territory however they want. We, I would imagine, though, very strongly hear on a recurrent basis that people want to know what is going on; people need to understand in their own language; people need to be told not after it is done, but while it is happening, while things are still in process. We will certainly reflect that, I think it is fair to say.

We have about five minutes left, and we have got time for whatever you guys need to discuss.

Mr VASHIST: This is a technical question. It would be good if I could have the information available later.

Mr CHAIR: We will also provide all of this that we have given you, to leave, but I am happy to answer any questions now if we can.

Mr VASHIST: With our partners in South Australia and Western Australia, are there statistics of feedback specifically from South Australia, APY lands (Anangu Pitjantjatjara Yankunytjatjara lands). How have things been reciprocated there if the legislation is available, and in Western Australia in the Kimberley and the Pilbara? How has that been received and actioned in these regions?

Mr CHAIR: We can dig something up on that. As a broad observation, each jurisdiction's VAD situation works independently. You cannot work across a border as it were. The kind of situation we pointed out before, still happened within Queensland, even though there are people on the New South Wales border side, they got exemptions to do everything—go to whoa—within Queensland.

In terms of how the numbers and uptake, I am guessing is what you are asking about in those jurisdictions. We can make some inquiries and find out whether or not there has been uptake in those jurisdictions.

Off the top of my head, and do not hold me to this, the one place that has seen growth in VAD uptake more than anywhere else, which is all pretty consistent, is Queensland. In Queensland they have a review board paper and we may be able to get more information from there. That may not reflect Indigenous people necessarily taking up the option so much as people who are regional and remote and older retirees. That may be why there is a slightly higher number there. But we will find that information for you and get back to you as soon as we can on it.

Mr VASHIST: Thank you.

Mr CHAIR: Likewise, we are still open to receiving submissions. Anything you want to give us on paper or via the phone on the hotline, all of that is available until the end of this week, until Friday. That is one thing.

Pennie, did I see your hand? Did you want to say something?

Ms COWIN: I have sat in a few of these consultations before where they have came out to the Barkly area, they have asked us questions and we have all put forward about …

Mr CHAIR: And then you never hear from us ever again?

Ms COWIN: Yes. Particularly with the remote communities, the Indigenous languages, the stuff like that, how much of what we are saying is actually going to go back and be covered(?) in the report?

Mr CHAIR: I hope a lot of it.

The limitation is simply one of time at the moment. We wrap up our consultations and data collection at the end of this week, having done that for the last four weeks. We are, under the terms of reference, asked to report back to the Attorney-General in some form by the end of September. That is not a lot of time, as you can appreciate. The hardworking staff behind me are pretty much working 24/7 to keep the show on the road and get all the data processed.

I hope that the report will be a detailed one and be able to capture as much of this information as possible. I think it has been great information that we have been able to capture across the Territory. Our commitment is simply to produce the best report we can, the best detailed drafting instructions, if appropriate, we can and then pass that to the government. Once it is in the hands of the government, it is only right for us to say it is out of our hands then. Our duty ceases once we finish the report, sign off on it, table it in the parliament, and then the government can decide to act on it the next day or not or whatever might happen.

That also includes, Pennie, I guess frustratingly, the feedback mechanism. What we can undertake as a committee, without overstepping our bounds is—I lived a previous life as an academic and I used to do a lot of research like this and I would always tell people who I spoke to, when I spoke to them and interviewed them, this is what I am going to do with your information. When I am done, I am going to get back to you on this date to let you know what has been happening.

It is something we will have to talk about as a committee, but without getting in the way of the government, I do not see any reason why we as a committee cannot reach out to the people that we have spoken to along the way to simply say, 'This is where the process is up to'. We will make an undertaking to keep in touch with you on how things are progressing, within our limitations. We obviously cannot speak for the government.

Ms COWIN: I am just wondering how much the homelands people are going to be actually heard for this when it comes to the final draft. It would be very—as Sid said, they will not come to the table for cultural reasons; you have got to be out there. Is that going to be a big part of the draft?

Mr CHAIR: So far we have managed to get out on the ground in a number of communities. At least in a handful of places, we have sat in the red dirt surrounded by a bunch of people in a yarning circle kind of situation and got as much information as we could, albeit it through translators. It is an obvious limitation that we do not have six years or even six months to do this work. We are not going to be able to cover off every homeland and community and hear from everyone. The people we have heard from in Ngukurr, Numbulwar, Borroloola and Papunya et cetera et cetera, we will certainly make sure that we capture as much of their voice as we possibly can.

Mr HOLBROK: One of the problems is about being heard—do they want to hear? Are they listening?

Mr CHAIR: That is a very good point. There were some places that we reached out to that we wanted to go to and who, for one reason or another, said, 'Now is not a good time for us', or that they were not interested in participating. Generally speaking, it was not that they were not interested; it was that there is sorry business at the moment, it is not a good time to come out to community X.

Mr YOUNG: A lot of the restriction that has been put on us is the time factor. The government have said that we need to report by the end of September. We have reached out to communities. Some communities have been willing to hear from us; others have not for various other reasons—sorry business, as Tanzil just mentioned.

Back to Pennie's point, yes, we have met with a few Aboriginal communities, but not any homelands—or been out to any homelands physically.

Mr VASHIST: I know time is of the essence, thank you, Dheran and Tanzil.

Just for the record, I will emphasise and recommend that you guys do consider visiting homelands. Being Barkly, I will definitely flag Arlparra and the Utopia homelands. If you look at the statistics in the Northern

Territory, the suicide rates remain high and they are pinned down to geolocations where—I am not really proud to say this—we have some real challenges in those regions.

Mr CHAIR: It is very useful to know.

Mr VASHIST: This is where we need to emphasise a visit in that specific region.

Mr CHAIR: I am trying to be the neutral umpire, if you like, guys, on all of this. The challenge here is that we have got some people who would like us to spend much, much longer and cover everywhere and other people saying, 'Just get on with it; we just want this done already.' All we can do as a committee is work within the bounds of what we have been asked to do. All of us accept that it is imperfect. I would very much like to go out to a number of the places you have mentioned. Our schedule wraps up, as things stand, this Thursday. I think we would be lying to you if we said that we are likely to get out to Utopia.

Mr VASHIST: I appreciate the honesty, thank you.

Mr CHAIR: It is just we have to be frank about it.

Mr YOUNG: We have spoken to people, obviously, from homelands.

Mrs CARLSON: We have spoken to people who do represent some of those areas that you are speaking about. In many of the communities we have had a lot of the elders who speak for their communities. It has been quite a positive response actually.

Mr KERLE: They have been very, very consistent in the message.

Mr VASHIST: It has going to be game, but I would recommend if you want to tackle this as a whole, front up to the Central Land Council and the Northern Land Council full delegation meetings and have a locked in private conversation if need be, but this is …

Mr YOUNG: Again, it goes back to our restrictions of the timeframe, because the full council meetings will not necessarily fit within the timeframe we have had. That has been our discussions within meetings.

Mr CHAIR: Dheran is right. What we can say is that the very first thing I did was write to all the land councils to ask them to get involved. But Dheran is right; if it does not fit in with everyone's schedule, we cannot just make everyone dance to our timeline. If you are unavailable, you are unavailable.

Mrs CARLSON: Which is why we did the consultation paper and asked for submissions as well.

Mr VASHIST: Before you guys close the recording, I must commend this committee because it is a very sensitive topic and you guys are doing some great consultation. I ran into you in Alice Springs, appreciate you reaching out and doing this all around where you can with the best possible timeline you have been provided. We look forward to reading the recommendations. Once again, a sincere thank you on behalf of the Barkly Regional Council.

Mr CHAIR: Not at all, and from our side as well, thank you so much for taking the time. Everything we hear, everywhere we go, adds a little bit something more to our understanding.

Pennie, just to come back to your point, we will do our very best to reflect everything that we have heard in the places we have been to and been able to hear from. Hopefully, that will provide enough of a representative sample of data and insight to add to the existing data and reports to provide the government a basis to progress the agenda on voluntary assisted dying in the Northern Territory.

Thank you again, guys, and we look forward to hopefully staying in touch and moving forward together.

The committee concluded.
