HEALTH AND ENVIRONMENT COMMITTEE

Members present:
Mr AD Harper MP—Chair
Mr R Molhoek MP
Mr SSJ Andrew MP (virtual)
Ms AB King MP
Ms JE Pease MP
Mr ST O'Connor MP

Staff present:
Ms R Easten—Committee Secretary
Ms R Duncan—Assistant Committee Secretary

PUBLIC HEARING—INQUIRY INTO THE HEALTH AND OTHER LEGISLATION AMENDMENT BILL 2022

TRANSCRIPT OF PROCEEDINGS

TUESDAY, 31 JANUARY 2023

Brisbane

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The committee met at 10.23 am.

CHAIR: Good morning. I declare open this public hearing for the committee's inquiry into the Health and Other Legislation Amendment Bill 2022. I am Aaron Harper, the member for Thuringowa and chair of the committee. I would like to start by respectfully acknowledging the traditional custodians of the land on which we meet today and pay our respects to elders past and present. We are very fortunate to live in a country with two of the oldest continuing cultures in Aboriginal and Torres Strait Islander peoples, whose lands, winds and waters we all share.

With me here today are: Mr Rob Molhoek, the member for Southport and Deputy Chair; via phone is the member for Mirani, Mr Stephen Andrew; Ms Joan Pease, the member for Lytton; Ms Ali King, the member for Pumicestone; and Mr Samuel O'Connor, the member for Bonney.

On 29 November 2022, the Hon. Yvette D'Ath, Minister for Health and Ambulance Services, introduced the Health and Other Legislation Amendment Bill 2022 into the Queensland Parliament and referred it to this committee for detailed consideration and report. This hearing is a proceeding of the Queensland Parliament and is subject to the parliament's standing rules and orders. Only the committee and invited witnesses may participate in the proceedings. I remind members of the public that they may be excluded from the hearing—I am sure you will be fine up in the public gallery—at the discretion of the committee.

These proceedings are being recorded and broadcast live on the parliament's website. You may be filmed or photographed during the proceedings and images may appear on the parliament's website or social media pages. Please turn your mobiles phones off or to silent mode.

DALE, Dr Brett, Chief Executive Officer, Australian Medical Association Queensland

CHAIR: To start today's proceedings we welcome, from the Australian Medical Association of Queensland, Dr Brett Dale. Dr Dale, thank you for your submission to the inquiry. Would you like to make an opening statement before we start questions?

Dr Dale: Firstly, thanks for the invitation to give evidence this morning. As the peak body representing Queensland doctors, we are extremely pleased to see key aspects of our submission included in the bill. Most welcome were the amendments to make hospital and health services and their boards responsible for staff health, safety and wellbeing and to require them to implement measures to support that responsibility. We have been advocating for that for over two years now, so we think it is a step in the right direction.

Our health workforce faces unique risks every day in their jobs on the front line. They deal with people who are critically unwell, infectious and distressed and can suffer physical and mental harm as a result of this. Indeed, the amendments are an important first step towards creating healthy and supportive work environments so our doctors, nurses and allied health practitioners can continue to deliver high-quality health care to Queenslanders.

To ensure the changes are a success, we submit that the hospital and health services must be provided adequate funding to fulfil these obligations. We also call for independent evaluation of all associated measures implemented by each of the hospital and health services. These evaluations must be published annually so individual hospital and health services can be held accountable for all public investment made in the interests of the health workforce.

Secondly, we want to acknowledge the sensible changes made to the bill to protect health practitioners' rights to natural justice. Following direct advocacy by AMA Queensland, the bill will amend the Medicines and Poisons Act 2019 to remove Queensland Health's ability to publish the administrative action register on its website. We note that the department will still be able to disclose information about administrative action taken against persons who have dealt with medicines and poisons in an inappropriate way, but on a case-by-case basis and only where it is in the public interest. This is a balanced approach and will better protect our health practitioners from being unfairly named for simple mistakes.

We acknowledge Queensland Health's legislative policy unit for their genuine engagement and sensible proposal to resolve our concerns. Their approach directly contrasts that of the Queensland government regarding the recent national law amendments permitting Ahpra and the medical boards to name and shame health practitioners before any finding of guilt. AMA Queensland remains strongly opposed to the violation of all health practitioners' fundamental rights to natural justice.

Finally, I turn to the submission concerning the Queensland Cancer Register. Whilst we support the amendments in principle, they impose a significant additional burden on pathologies, diagnostic imaging practices and the hospitals. We appreciate that Queensland Health is providing these services with a 12-month transition period and the technical support to comply with the increased obligations. That said, the amendments extend the offence provisions to all notifiers in breach of the notification requirements.

We reiterate that AMA Queensland does not support unwarranted prosecution of health professionals who act in good faith but fail to comply with administrative requirements. These workers should be supported to provide valuable, population-based data with adequate practical assistance and funding, not punitive measures. Our health workforce is overstretched and such penalties only serve to alienate and victimise them further. We must support and protect our health workers as they so tirelessly do for us.

Since our submission was limited to those aspects of key relevance to the medical professionals I do not propose to comment on other aspects of the bill. I am happy to take any questions from the committee.

CHAIR: Thank you very much. We will start with the deputy chair.

Mr MOLHOEK: Thanks, Dr Dale. You go into a little bit of detail around the protection of health professionals and concerns around disclosures and the right to natural justice. I just wondered if you could give us some examples of cases or incidences where that would be of particular concern.

Dr Dale: If we refer to Ahpra's new powers that have been legislated, in fact Ahpra and the OHO can declare and make public announcements of a practitioner who is under investigation. We think that fails to address natural justice. The act enables the statements to be withdrawn. When you think about the big wide world of the web, once a practitioner has been tarnished it is irreversible. We do not for one minute want to protect practitioners who have committed an offence or are practising in a way that is not consistent with the profession, but we do want to support natural justice first and foremost. In terms of an example that I would give, in Queensland it has been applied once that I know of and that was about an infectious control measure and that was a dental practice. The basis of that decision was not confirmed. There was a lot of luck in that decision, but there was no way that that business would continue to practise had that decision been incorrect.

Ms KING: Thank you for coming in today and for your contributions to the bill. I am sure that we are all pleased to see that the AMAQ felt that the process by which Queensland Health worked through your concerns had a good outcome. I am interested in your comments regarding the Queensland Cancer Register. I am unable to pull it up using my program at the moment, but my mind is turning to the submission by the Cancer Council Queensland in relation to the underway technological solution that will enable the reporting of cancer incidences through diagnostic imaging services. Have you had a chance to take a look at that particular submission or are you aware of that particular technological solution?

Dr Dale: No. I am not aware of the content of the submission by the Cancer Council.

Ms KING: It may actually have been—and, again, I apologise for not being able to pull my submissions up—the diagnostic imaging peak body that made the submission in fact. More broadly, are you aware of any technological approaches underway that would serve to smooth the reporting requirements in relation to the diagnostic imaging industries?

Dr Dale: That is our understanding. During consultation with Queensland Health we put forward from our radiologists the concern about the administrative liability of this reporting. Queensland Health has indicated that there is a year's transition for the process and it is supporting the development of technology which will make that simplified. One of the things that we applied is when we talk about all professions in health we want people working at the top of their scope of practice so they can do what is really important for the health and safety and wellbeing of all Queensland. The reality is that we get so distracted by the administrative liability. Even if it was not a technology solution we need to look at the appropriate workforce to administratively support the clinicians in that space, but we do understand and believe that there is technology being developed to support it.

Ms KING: As a supplementary question, I suppose I would like to explore the AMAQ's views of the current effectiveness of public health data gathering in relation to cancer incidences, because it seems to me from the materials I have read that there are gaps in that space at present and that with your organisation's commitment to better public health there might also be some views about the ultimate outcomes. I am interested in exploring your view on whether that additional reporting will have benefits as well as potentially present difficulties.

Dr Dale: Data is key. It is the basis of all good evidence and scientific decisions. What we are poor at though is managing that data. I think post COVID we can see a movement from Queensland Health to get into that space. Just recently we participated in a discussion with an external adviser for Queensland Health about how they would better produce data to make scientific judgements. In terms of cancer and its prevalence across Australia and the data that is available, it is the area of medicine that has had the most progress over the years because it is so deadly. There are so many other public health issues we could be seeing the same benefits from if we managed that data appropriately.

Mr O'CONNOR: Dr Dale, your submission said that it would be a significant extra burden on pathologists, diagnostic imaging practices and hospitals. Can you quantify that burden and how that was arrived at? That is pretty significant. That makes out that it is going to be quite a big impact on these practitioners. Can you quantify how you arrived at that?

Dr Dale: Sure. If I was to give other examples of changes to reporting and checks that have been implemented over the last two years, we have had numerous concerns from members about that liability and the impact on seeing the number of patients who are actually waiting. QScript would be a prime example for that. No-one argues or disputes that the technology that has been designed does not improve the safety and the management of narcotics, but what it does do is create a burden for the practitioner who is trying to manage the health of the patient who is subject to the full force of the law if that system is not used, but it is not integrated into other systems so you have to log out and log in. Those administrative liabilities are huge. They do not sound much in isolation, but every time we introduce something else it is a real concern. Getting that integrated system that gives a system approach in one system where you can access everything would be perfect, but reporting individually through numerous platforms is a liability and slows down the access to the number of patients that need to be seen.

Mr O'CONNOR: So the support is there because the clear evidence is that this will increase our understanding of cancer, but you just want it to be smooth and easy?

Dr Dale: Absolutely, yes.

Ms KING: I found my submission and it is from the Australian Diagnostic Imaging Association, and I note that it supports the change to the legislation while also looking forward to the development of the technological solution. More broadly, given that it is a peak body for the industry, I would ask you to comment on its support for these measures.

Dr Dale: We actually support it, and I think what Sam was just clarifying from our perspective is that it is not the process that has been implemented; it may be the design. If there is a system, it needs to support and simplify that reporting process. At the moment everything is done in isolation. Every time we change a process of reporting there are new forms to be filled out. These are not simple, fully integrated technology systems that talk to one another. Primary care does not talk to tertiary care and there is no integration, so every time someone sees a patient they start again, and it is the same for reporting data around findings such as cancer. So we fully support what the diagnostic imaging peak body is saying—that is our view—but we want to make sure that the clinicians and administrative staff are supported with the right technology and workforce to implement those changes.

Mr ANDREW: I have a quick question around the use-by dates on some of the administered medicines. Is that captured in some of the things that we are looking at implementing to make sure that use-by dates are adhered to and checked?

Dr Dale: I am not sure in what context. If you are talking medication, the standard approach to any utilisation of medication is that use-by dates are always checked and clinicians administering that medication are responsible for that check.

CHAIR: What other priority health, safety and wellbeing issues at present do you hope will be improved by the proposed requirements to support public health service staff?

Dr Dale: For seven years we have been doing what we call a resident hospital health check. Year in and year out you get a response of up to about a thousand doctors eligible for that survey. Every year we get near 40 per cent of all doctors participating in that claiming that they have been

bullied or harassed in the workplace and feel stressed to some degree. We have had suicides across Queensland. Each year we have provided that feedback to the hospital health services in a collegiate way. It was not about naming and shaming, but it was to give them the information to address that.

In every year out of that 40 per cent something like 60 per cent feel like there has been no resolution or action to address their bullying or harassment complaint. That is seven years running with no change. We know that the legislation and a board being accountable will be that change. We called for it about 2½ years ago. We saw some evidence that it was being practised in South Australia and internationally and if there was one thing that made or changed the behaviour of a board or a governing body of any entity it was the accountability issue. Even though we had exposed the findings publicly there had been no action, but we do think that moving to have them accountable legally will see a real difference in this space.

CHAIR: You talk about the last seven years to capture that data. Were you doing anything prior to that?

Dr Dale: To be honest, I cannot confirm that. I looked at the current survey that we have that has the same questions year on year and that has been for seven years running.

Ms PEASE: As a supplementary to that, with regard to those surveys, is that just surveys of the HHSs or are you surveying other private practices?

Dr Dale: No, the HHSs only.

Ms PEASE: Do you undertake a similar sort of survey with other doctors who operate in private practice?

Dr Dale: We do. It is not the same, so it would not have the same data that we could compare and there is a difference and it is really hard. When you think about the employer under those arrangements, the consultant tends to be the employer there and he or she would have surgical assistants working for them. It is a different environment, so it is really hard to capture that data.

Ms PEASE: But would those practitioners still be members of the—

Dr Dale: Yes, absolutely.

Ms PEASE: So you would still have access to them as individuals to obtain data from them whether or not they are surgical assistants or registrars or whatever?

Dr Dale: Yes, that is right. We have just established this year a committee of specialist consultants for that purpose. We will expand our reach to see what the practice is across the private sector.

Ms PEASE: It would be interesting to see because we see a lot of media around that and have seen some stories about that. Has there been any research done in other states around that area?

Dr Dale: Not that I am aware of.

CHAIR: Thank you very much for your contribution today. We always welcome the contribution of the AMAQ, so thank you very much.

DWYER, Ms Kellie, Professional Officer, Queensland Nurses and Midwives' Union

KLIEVE, Dr Helen, Research and Policy Officer, Queensland Nurses and Midwives' Union

SHEPHERD, Mr Jamie, Professional Officer—Team Leader, Queensland Nurses and Midwives' Union

CHAIR: Good morning. Welcome. We always appreciate the QNMU coming to our committee hearings and we thank you for your submission. I invite you to make an opening statement.

Ms Dwyer: We thank the committee for the opportunity to speak today with you. Appearing with me today are Dr Helen Klieve, the QNMU Research and Policy Officer, and Mr Jamie Shepherd, our QNMU Professional Officer—Team Leader. I would like to acknowledge the traditional owners of the land upon which we meet, the Jagera and Turrbal people, and pay my respects to elders past, present and emerging and also pay my respects to any First Nations people present today.

We represent the interests of our membership of close to 70,000 nurses and midwives who provide health services across Queensland. They work in a variety of settings, from single-person operations to large health and non-health institutions in the public and private health systems. Today I and my colleagues will speak on the issues raised in our submission regarding the Health and Other Legislation Amendment Bill 2022.

We commend the committee for its work in updating and modernising the legislative approach to the management of health issues addressed in the bill. The enhancement and change in systems is clearly important to make our legislation more relevant and appropriate. An overarching theme across these amendments relates to the management of information and a balance between privacy and personal and public needs. Increasingly, there are calls for greater transparency. Such transparency can contribute to achieving accountability, but we do recognise there is a balance of interests in all of this.

In our submission the QNMU has supported most of the proposed amendments that allow greater collection, disclosure or processes for the management of information where it is in the public interest. Two suggested amendments under the Medicines and Poisons Act 2019 that relate to the disclosure of information regarding practitioners are noted. In both of those the proposed amendments will support disclosure of personal information where this is judged to be in the public interest or, more explicitly, for regulation, safety and compliance purposes. While the QNMU has supported both of these amendments, it has also stressed the need for care in the management of personal information in doing so.

The proposed amendment on which we have raised concern relates to approaches for managing the wellbeing of health staff. This is an issue on which we have also previously expressed concern. The proposed amendments require the hospital and health boards and hospital and health services to proactively consider ways to support staff health, safety and wellbeing. We acknowledge agreement with the proposed amendment regarding the need for a focus on wellbeing. Our concerns relate to the priority and approach through which changes will be managed and achieved under the proposed amendment.

As raised in our submission, in recent member surveys around 50 per cent of our members identified concerns regarding workplace violence as a key issue. We see the safety of health staff as an urgent issue requiring effective action to bring greater protections. In focusing on the impacts on staff of safety issues in the work environment, it is also important to recognise that such effects extend to the outcomes of patients in our health systems.

We do recognise that an objective of the proposed approach is to provide flexibility to the HHBs and HHSs in how they manage these issues. However, given the immediacy and importance of these issues, the highest priority would seem to be needed, with any plan being made publicly available to enable appropriate accountability with regular reporting against the goals. As we have suggested in our proposals, current initiatives with which the QNMU is working with Queensland Health suggest a pathway forward. For example, the development of a publicly documented nursing and midwifery report card, a 2020 election commitment, integrating the elements of a positive practice environment, PPE, is one step by the government towards achieving change.

While this approach will specifically address issues around physically, psychologically and culturally safe work environments, it is widely recognised that the benefits of such a safe environment also extend to the quality of health care received. The greater transparency associated with the

delivery of the report card also aligns with greater shifts in transparency and associated accountability in the provision of health services. While the QNMU is proposing a more transparent and accountable approach by hospital and health boards and hospital and health services in addressing staff health, safety and wellbeing, it is felt that the approach adopted can retain the level of flexibility needed for the operation of individual groups.

We look forward to questions and further discussion relating to these issues—in particular, ways to progress the issues of a safe workplace, supporting nurses and midwives and the best outcomes for all Queenslanders. We are happy to address any questions from the committee.

Mr MOLHOEK: Thanks for joining us today. We appreciate your participation in the hearing and the submission you have made. I would like to ask some questions around the health and wellbeing of staff generally. You note in your submission that, in the most recent survey of 2022, 78 per cent of respondents cited dangerous workloads as an issue. Morale, distress and fatigue are other key issues. I note that this legislation seeks to put some measures in place to address some of those concerns. I am interested in your comments. Are those measures enough? How concerned are you about the health and wellbeing of our frontline workers within our health services? The statistics that we see are fairly alarming. In your opening remarks I think you used the word 'incidents', so has there been any tracking of security or significant incidents where people's wellbeing is directed impacted by an assault or the behaviour of patients?

Ms Dwyer: To your latter point with regard to the tracking of incidents, there are probably two ways in which that evidence could be obtained either by us or through the employment of our members. The use of incident reporting platforms that are available within the relevant hospitals and other health services would obviously be information that we would seek at the point in time at which we require it. Often the evidence we have that comes from members directly would relate to the injury at the time or as part of any broader grievance process we might be supporting our members through. Those particular pieces of information I do not have readily available at the moment. We are happy to provide some data that could strengthen the evidence we put forward in our submission, noting any particular cases that may draw out further information.

Within the QNMU we have work health and safety officials and WorkCover officials, and it is those two roles that primarily sit with our members to understand what those incidents have been. We do work very well with some of the occupational violence units within Queensland Health as well. We have been a very pro-active stakeholder in how those systems and services have been developed and how they continue to support our members in the workplace. In a broad sense, certainly we are aware of incidents. There would be details we could provide if required which would have to go through the relevant officials who oversee that work more so than we do.

To the other matters around how concerned we are and if the measures are enough, we have always been really concerned about the safety and wellbeing of any nurse or midwife working within Queensland regardless of the sector, particularly across our membership. This data is not information that has been known to us in more recent years. We appreciate the anecdotal evidence that we might receive through conversations with our members alongside the survey data we receive. The survey data in most respects supplements and supports the concerns we have based on very broad and general conversations we have with our members across many forums. We remain very concerned about the risks imposed upon nurses and midwives working within Queensland health services, regardless of which type of service it is.

In relation to whether the measures are enough, one of the concerns we have around that is maybe the time frame in which some of these processes will be implemented. We feel there needs to be a greater urgency in how any amendments or changes that are sought to be made are brought forward. We feel that a matter that has been on our radar—and I suspect on the radar of many—for some time is the urgency with which we feel this matter needs to be addressed moving forward.

Mr Shepherd: The causes of aggression and violence against nurses can sometimes be quite complex and hard to pin down to one. It can be a combination of factors. The positive practice environment we have been pushing for a number of years now is now being selectively picked up by Queensland Health. We have developed some positive practice standards.

One of those six standards is the need for nurses and midwives to work in a physically, psychologically and culturally safe environment. In my mind, it is about going to work at the start of your shift looking forward to going to work and being able to do your job safely and competently, then going home at the end of your shift thinking you have done a good thing today. You have achieved something: you have made people better. You should not be going to work worrying, 'Am I going to get hit today? Am I going to engage in a violent incident because I have to because I am a nurse or

a midwife?' Perhaps we could provide some de-identified incidents of where nurses have been seriously assaulted—on condition that those members are happy to share that information—because it does happen from time to time. There are certain areas of nursing where it happens more frequently, and we could provide some examples of that as well.

One of the things we have been pushing for since 2016 with the implementation of ratios is the appropriate application of those ratios and the implementation of them at the ward level. We have seen that certain elements in varying hospital and health services have been somewhat inventive in how they apply the ratio and not applying a strict ratio, which in our mind was one to four, one to four and one to seven: one to four early shift, one to four late shift, and one to seven night shift. Some units within HHSs are saying, 'If we have 20 patients, we just need five nurses.' That is one to four on day shift in total, but one nurse might end up with six patients and another might end up with two or three. That is why I say some places are being a bit inventive. That contributes to creating safety issues for those nurses because they have too many patients. On top of that there are safety issues for the patients, particularly around safety and optimal clinical care, if the nurse who is looking after you has too many patients.

Ms PEASE: Thank you very much for coming in. I would like to acknowledge all of your membership and thank them for their dedication and commitment to Queenslanders. I note in your submission that you made some suggestions around fluoride in the water. You made a suggestion that it should be managed at the state level rather than the council level. Can you elaborate on that and give us some more insight into that?

Ms Dwyer: Over the years we have developed our own fluoridation policy. That has been informed by our membership across the state. It has been our position through those policies that we support fluoridation in Queensland. We recognise that there is evidence across Australia that supports the position we have taken over many years.

With regard to the recommendation that it sits within state jurisdiction rather than local councils, it is to ensure consistency and equity in the distribution of fluoride across Queensland so that people's dental health is equal and it is the same, at a very basic level, for everyone. That is our position in a broad sense. We do not have a copy of our fluoridation policy today, but if the committee wishes to review that we can talk about providing it out of session.

CHAIR: We will take that question on notice, if you can provide that by 7 February.

Ms KING: I echo the member for Lytton's comments in relation to your members. I want to particularly thank you for your very thorough submissions. Your submissions are always incredibly helpful when we get together as a committee and I want to acknowledge the work involved in that. Your comments about occupational violence and workplace safety to my mind segue slightly to the amendments regarding the role of security officers in health workplaces, particularly hospitals. You noted your support for those amendments. Could you provide any commentary about that working relationship between security officers and your members in health settings? How will these amendments change life for your members in their wards or EDs?

Ms Dwyer: In a very broad sense, as someone who has worked in high critical areas where security staff have been a very common feature in our workplace and as someone who now represents and speaks with members a lot about these issues, I can say that the value of well-trained and supportive security staff across the health services is enormously appreciated. Yet there still can be on occasions those tension points between where those boundaries stop and start. We appreciate that more in those environments where critical care is being provided or where there is a more volatile casemix of patients or clients coming through—that there is immediacy to manage a situation or there is immediacy to manage a health event.

We do value the work that our security colleagues do across all services within health. A lot of our more detailed experiences come from our members who work in those more high-risk or critical care environments where that is a common feature of their work. I will defer to Jamie for any further comments given his equal experience.

Mr Shepherd: In the context, part of my portfolio as a professional officer is to assist members working in mental health areas. As we know, a number of those areas are high secure, working with clients who can potentially become violent. Those nurses work very well with the security officers. They really appreciate the work the security officers do in assisting to protect their workplace health and safety.

We have had incidents where there have been violent clients in a particular unit, and I am probably not at liberty to name the unit. In one case, the nursing staff were not able to manage that client. They had not been given the correct professional management training to be able to manage

that client, so we made a push and the service agreed to provide two security officers. The staff worked well with those two officers, but when that client was moved to another area and became more settled, the security officers went somewhere else. A similar client was then admitted and we had considerable difficulty getting those security officers back—whether that was for financial reasons or whatever. The point is that the health staff were very appreciative of those security officers and worked closely with them, and it was for the best care of the client.

I first worked in a secure mental health unit in 1981, and the last time I worked in a secure mental health unit was in 2000. Over the course of those 19 years, I never saw a security officer. Part of the reason for that was that all of the nurses working in those units were qualified in mental health nursing. One of the issues we see at the moment is that a lot of mental health units have trouble attracting qualified mental health nurses so they have new graduate nurses who may or may not have had some mental health training in their undergraduate degree coming to work in that unit. That creates issues for them, particularly around de-escalation and those sorts of skills in managing potentially aggressive incidents. We see that incidents become acute because of that absence of good de-escalation. That is my view having come from those environments.

I went to a mental health forum a couple of years ago just before COVID which was run by the office of the chief nurse. At the forum were nursing directors from most mental health units in the state. I mentioned to them that Victoria has a condition in their enterprise agreement that if you are a registered nurse in a mental health unit you must be qualified in mental health nursing or working towards that qualification. One of the nursing directors from one of the HHSs said that if that condition came into Queensland we would have to close their mental health unit because we do not have that degree of mental health nursing qualifications.

That is why we have been pushing through some of the government election commitments that the government should be promoting and funding to a degree scholarships in mental health nursing, either the graduate certificate or the graduate diploma in mental health nursing. Victoria does that. Victoria offers $300,000 a year for scholarships in mental health nursing, and you can see how that works through the Chief Mental Health Nurse in Victoria. One of the other things we have been asking the government in Queensland to promote is the establishment of a chief mental health nurse for Queensland.

CHAIR: That is very insightful and I am sure the QNMU will continue to advocate for its members in that space.

Mr O'CONNOR: Thank you for those comments. It is very interesting to note and worth looking into because I have heard some real horror stories from the mental health pod down at the Gold Coast Hospital, so I appreciate those comments. I want to get more clarity on your recommendation for flexible approaches with the publicly reported staff wellbeing plans. Could you run through your view of what that could look like? Does that just mean it is going to vary between the HHSs? You mentioned confidentiality as well. Can you flesh that out a bit more?

Ms Dwyer: When we talk about the public reporting on wellbeing, are you referencing some of the comments we have made about the positive practice environment standards?

Mr O'CONNOR: Yes. There were two recommendations where you talked about the flexible approaches. I wanted a bit more clarity on that.

Ms Dwyer: With respect to flexibility, it has to be cognisant of the environments we all work within. However, we are currently working through how that reporting can look when we consider the standards that we have published and are evidence based—ensuring that, when we have those core reporting questions that all employees as nurses and midwives can access and undertake, it does recognise there is this degree of change and variability in that outward facing report card we are continuing to work through. Helen was referencing more in the flexibility through some of her work. Was there anything further we noted in that respect?

Dr Klieve: The issue raised when we spoke to Queensland Health was they felt the reason for the type of amendment that was suggested was the health boards needed flexibility. What we were saying is we felt there needed to be public disclosure and there needed to be a formal process but that could be done in a flexible manner across different organisations. I think that is where the flexibility reference came—it was more recognising there are a lot of ways to do things flexibly that are still publicly disclosable and transparent.

Mr O'CONNOR: That it was not rigid from the top down. I understand.

CHAIR: That concludes this session. We have gone over by a couple of minutes, but we deeply appreciate the QNMU's insightful contributions to our work. Thank you for being here today.

WATSON, Mr Barry, Senior Advocate, Australian Workers' Union of Employees, Queensland

CHAIR: Welcome. Would you like to start with an opening statement before we move to questions?

Mr Watson: The Australian Workers' Union thanks the committee for allowing us to come today and speak to the submissions we have made to the bill. Just so the committee is aware of the Australian Workers' Union's representation in this area, I will mention that we cover basically all the operational employees within Queensland Health. Most of those people are frontline staff. They are wardies, they work in the catering areas, and there are some clinical assistants as well. They are all frontline staff, they all work in clinical areas, and they are at the coalface of what happens in a hospital. We also cover security staff. I was listening with some intent to the comments of the Queensland Nurses and Midwives' Union and I will comment about that a bit later.

We support the changes because they will lead to an improvement in safety for employees within hospitals and other health facilities. We support any moves in that direction 100 per cent. The thrust of our submission is that we think this is a missed opportunity to include in the legislation the provisions in the Work Health and Safety Act that could be of assistance to achieving the aspirational goals contained in the bill. If I reference that, the first policy objective of the bill is to—

… strengthen protections for the physical and psychological wellbeing of the public health workforce by requiring Hospital and Health Boards and Hospital and Health Services to proactively consider the health, safety and wellbeing of staff of public sector health service facilities …

I say that is an aspirational statement because it says 'strengthen protections', and it also says to consider ways of achieving that. That leaves it up to the boards, and the boards are autonomous to some extent. That is a perennial issue that our union deals with within the health system in Queensland. We have Queensland Health and the minister who makes decisions, and then we have the health and hospital boards which may or may not decide that they need to comply with those instructions.

From our point of view, the Work Health and Safety Act is Queensland government legislation made and put in place by this parliament which has the charter of making workplaces safer for all employees, including employees of Queensland Health HHSs. We believe the Work Health and Safety Act will be able to assist the HHSs to achieve the aspirational goal of strengthening the protections for the workforce as set out in the bill. The provisions in the Work Health and Safety Act, the regulations and the codes of practice can be used as a blueprint for developing strategies set out in the bill we are discussing here today.

For that reason, we seek that the bill be amended to include a reference to the work health and safety legislation. At the moment, it is optional as to whether the hospital and health services believe it is a relevant consideration when determining their policies with respect to the amendments in this bill. That is the main thrust of the submission we have made. We made that submission to the legal part of the department within Queensland Health when they sought our response back in October. For some reason, we are not acknowledged in the material as having made a submission. We certainly have an email back that said we did. Maybe it is because we continue to push for reference to the health and safety legislation in the bill. That may be the reason we have been cut out. I do not know.

I am not making any comments about that, but if there is some reason going down that path then that is quite disturbing to us. However, we do not have any proof of that and we are not alleging that today. Rather, we say that the legislation—the bill—and the amendments to the legislation should make reference to the Work Health and Safety Act. It is certainly my view that Queensland Health, because health is their business, perhaps put health ahead of workplace health and safety. I understand that and I am not challenging that because the health services that Queensland Health provide are great and we support those, but we also want to make the point that the HHSs as employers have responsibilities to their staff, whether they be nurses or midwives, doctors, other clinical staff, admin people—whom we do not cover—and obviously the operational people, whom we cover. We support any improvement to health and safety for the workers within Queensland Health, but we think that the legislation needs to reference the Work Health and Safety Act.

The other point I will make a comment on is the changes to the powers for security staff. To give you a bit of history on the security staff—and this is something that I listened to in the last discussion—security officers first came into the workforce when unfortunately nurses were being

threatened and assaulted when walking to their cars late at night from hospitals by an unruly element or probably worse within our community. The service has grown topsy-turvy—I suppose that is the word—since then and we now have security staff in hospitals.

Earlier the nurses' union talked about the fact that security obviously helps in the workplace. We represent the people who administer that help and they tell us very clearly that there are people who are quite aggressive. Some are affected by drugs and alcohol. I have seen a lot of videos where there have been incidents. Some of the patients are just drunk, but others have serious health problems that need to be addressed. The clinicians and the security staff have the difficult task of perhaps making an assessment in that regard about which it is—that is, it is someone who is going to wake up tomorrow with a hangover and move on or someone who is genuinely in need of health services. We say in our submission that the security staff are not qualified to make that decision and we think that that decision should be made by clinicians, whether it be a nurse, a doctor or some other health professional. That is the only point we make with respect to that.

We believe that a better structured and more consistent approach to the application of security across Queensland Health and the HHSs would go a long way to resolving the issues that nurses raise and the one that I have just raised. There are some issues at the margin, so we would 100 per cent support these amendments with respect to the powers. However, there needs to be some clarity as far as where the roles stop and start and where they interact.

That is pretty much the submission that we wish to make to this bill. We certainly do not want it on the record that we oppose it. We certainly support it. Any step in improving health and safety for not only the staff but also ultimately the patients and the people of Queensland is a great thing. We are fully cognisant that there are not just employees in hospitals; there are actually patients. We acknowledge that that is why hospitals exist—that is, to provide services to those people—but we think that more work needs to be done on getting the mix and the balance right. Thank you.

CHAIR: Thank you very much, Mr Watson. You reminded me that back in the eighties I was a wardie and one of your members before I joined the ambulance, so I totally understand where you are coming from and have a huge amount of respect for every role that people play in hospitals, particularly security people in the emergency department. It is a very complex area. The department did respond, taking your last point first, saying that security would work with the medical staff to get the assessment. A lot of those really complex cases can be under an emergency examination order where they cannot leave the hospital anyway until they are treated, but as a broader comment I certainly understand the interaction between security and the medical staff in those complex cases. I just wanted to touch on your workplace health and safety comments. You made a comment in your submission about unelected health champions.

Mr Watson: Yes.

CHAIR: I think the broader intent of this, the way I read it, is that health and wellbeing is paramount across every sector of the health workforce, and I was a former workplace health and safety delegate, so I totally understand where you are coming from in both aspects. Would it not be your view that everyone has a role to play in workplace health and safety and ensuring the wellbeing of staff?

Mr Watson: I agree with that statement 100 per cent, but what we are saying there is that section 74 of the Work Health and Safety Act talks about the ability to have a joint committee with management and staff and section 75 of the act talks about work health and safety representatives. Actually, I got that around the wrong way: it is 74 that talks about health and safety representatives and 75 about the committees.

What happens in Queensland Health is that there are very few committees that are established under the Work Health and Safety Act. They are actually management committees and our members find—and I am not sure about other unions' members—that it is difficult to get management of the HHSs to take on board the issues that our members raise. With some issues management say, 'We'll look after that.' Management appointed these people as health champions, but they do not have the powers of a representative under the Work Health and Safety Act to go and be part of an investigation. Management says, 'Thank you for raising the issue,' and then there are often difficulties in getting responses as to what happened with the matter that was raised. That is the sort of issue that happens when there is no reference to work health and safety in the legislation and that is the primary reason why we have asked that the bill be amended to include a reference to work health and safety.

We do not have any agenda to be disingenuous to the HHSs. We do not care about that. We just want to make every effort we can, along with our members, to make workplaces more safe. That is purely where we are coming from. We are not happy with some of these committees and the

management. We call them stooges—the unelected people—but we just want to get it working properly. Health and safety is something that is for everyone—management, employees and the client group, which in this case is patients. That is where we are coming from. We made this submission to this committee because we think this is a very important issue and we sought the opportunity to come and address the committee about our views. We think that this is a step in the right direction, but more could be done. That is where we are coming from.

Mr MOLHOEK: Mr Watson, so are you suggesting then that Queensland Health are not acting in the best interests of their employees and looking out for their health and wellbeing because there are gaps in the legislation currently?

Mr Watson: I think they are more interested in protecting the HHSs as an organisation. I remember in 2020 when the director-general became the employer of all employees in Queensland Health and the CEOs of the HHSs lost that delegation. There was a health and safety document—there were various documents produced—and one said that the first thing you do when an incident happens is notify the legal people. I would imagine that the first thing you do is care for the people who are injured, whether they be patients, members of the public who are visitors or staff.

Mr MOLHOEK: It is a bit ironic given that they are in a hospital.

Mr Watson: Yes. That is the sort of stuff that we want to change. We think it is a cultural problem and it needs to be addressed. We do not really care how it happens, but we just want it to happen.

Mr MOLHOEK: In the submission we received from the Queensland Nurses and Midwives' Union they talk about issues of dangerous workloads, moral distress and fatigue. Has your union looked at any issues around worker fatigue and workload management?

Mr Watson: Yes. It is always an issue when there is a budget that the government departments have to work under. We are always talking to HHSs and, indeed, Queensland Health about workloads for our members, probably not so much security but certainly wardspeople, catering areas and all the others as well. Through the enterprise bargaining process we certainly raised the issue of workloads and we do everything we can to get changes made so that workloads do not become excessive. An excessive workload means that the service that is provided ultimately to the patients is diminished, and that is not good for anyone. We think that workloads are a significant issue. We raise them all the time, things like backfilling when someone is not there. The government has announced that there will be an extra 30,000 staff over the next 10 years. There is a need to recruit more staff. I think Queensland Health, which want to be an employer of choice, should be able to demonstrate that they take health and safety seriously and workloads and all those other things.

Mr MOLHOEK: Would it be fair to say though that from a budgetary point of view it actually makes more sense to have more people available because if you have your current employees working longer hours and taking on extra responsibility you are also paying a lot more penalty rates, so it would actually be more cost effective to have more people? It seems to me that the culture has become fairly toxic and that a lot of Queensland Health employees are really carrying or shouldering an unrealistic workload and expectations.

CHAIR: I am going to take that as a comment, Deputy Chair, and ask if there is a question, because the member for Lytton does have a question and we are almost out of time.

Mr MOLHOEK: Just as a question on notice, do you have any datasets like the Nurses and Midwives' Union provided around worker fatigue and workload and dangerous workloads?

Mr Watson: Not current. I think COVID put our surveys of our members behind a little, but prior to then we certainly did do surveys. Job security was the most significant issue for our members and then a safe work environment was certainly in the top 5, and that could be from client abuse, it could be from excessive workloads or it could be from bad rosters which lead to fatigue. There is a whole range of issues that are perhaps interlinked. Like any organisation, Queensland Health HHSs do have certain elements of cultural issues that need to be addressed. I am not saying it is particularly bad in Queensland Health compared to other organisations, but it is certainly our view that improvements could happen.

Mr MOLHOEK: That was very diplomatic, Mr Watson. I will not place a question on notice around the stats though if they are three years old.

Mr Watson: I am not sure what I could produce. I am happy to have a look.

Mr MOLHOEK: That is fine.

Ms PEASE: I want to make a quick statement. I want to acknowledge the great work of your membership. I had the experience under another committee of visiting an emergency department and seeing their great work and the impact that unruly patients have. As you said, they might be drunk and wake up with a really bad hangover, but they could also be drug affected.

The patients who are presenting these days are very different and for your wardspeople and the security officers it is a really difficult job at different times. You mentioned during your opening statement that there needs to be more of an engagement between medical and security. I cannot remember your exact words but more streamlined, I think you said, around the medical and the security. That was what my question was going to be and you have covered it in your opening statement. We do not need anything further, but I did want to say thank you.

Mr Watson: Thank you.

CHAIR: Hear, hear, member for Lytton. I do have a question from the member for Mirani, who is on the phone.

Mr ANDREW: I do agree with a lot of stuff you say in here. In the minister's introductory speech she said, 'At its core, this reform must be about innovating the way we deliver care'. In my experience, the reference to innovation usually translates into the increased use of technology and automation to replace services and people's jobs. Does the union have any concerns about the rollout of technology coming at the expense of health and security workers' jobs?

Mr Watson: I do not believe technology will replace our members' duties. Probably 10 years ago there were a couple of robots trialled—I think one was in Townsville—to welcome people when they turned up at the hospital. I think someone who was looking for the emergency department was sent to the toilets. I know that is quite comical, but I think that was the end of the trial. Oscar, or something like that, was the name of the robot. I cannot remember the name.

Our members perform duties in the clinical areas that are labour-intensive, so I would not see that robots or technology would create a significant change there. In fact, our members do not have desks or computers so they are a bit detached from modern organisations and how they operate, which is a shame but that is how it is. We would object vehemently if jobs were going to be outsourced under any banner, whether it be technology or for any other reason.

I will make a comment in relation to the occupational violence unit, which implements a whole heap of health and safety reforms. When he retired about five years ago, one of the chairs—and he was a doctor from the RBH but I do not have his name with me—commented, 'The security staff are great and they have improved a lot within hospitals. It is unfortunate that, where the security function is outsourced, security services are not as good.' He put that down to the fact that where security is outsourced, the person who comes in from MMS and does a shift has no ownership or interaction with the other staff, so they do not really care as much. He made reference to the fact that teamwork within the emergency department or ICU, or whatever part of the hospital it is, is improved where the staff work together. I think that was the point he was making. Our union would oppose any outsourcing under whatever banner.

Mr O'CONNOR: This is more of a comment. The submission that you sent back in October is the appendix, is it?

Mr Watson: Yes.

Mr O'CONNOR: There is a typo in the email. I do not know if the email was sent, but legislation is spelled L-E-S-I-G, not L-E-G. Maybe you can check on your system if someone mistyped it, but that could be the mystery solved.

Mr Watson: I checked that out. Because we received an email back on 10 December—

Mr O'CONNOR: They confirmed it?

Mr Watson: They confirmed they received it.

Mr O'CONNOR: Never mind then. The mystery is not solved.

Mr Watson: No, I checked that, believe me. I would not be happy if we stuffed it up at our end. I would like to make one final comment. Various members of the committee have made complimentary comments about our membership. I thank those people for those comments. I will certainly take those back to our members.

CHAIR: Please do. Thank you very much, Mr Watson, for your contribution. We are going to have a short break.

Proceedings suspended from 11.33 am to 11.56 am.

CHESTERMAN, Dr John, Public Advocate, the Public Advocate

MATSUYAMA, Mr Yuu, Senior Legal Officer, the Public Advocate

CHAIR: If you would like to start with an opening statement, then we will move to questions.

Dr Chesterman: Thank you for the opportunity to be here. I acknowledge the traditional owners, the Turrbal and Jagera people, and pay my respects to elders past, present and emerging.

As members of the committee know, as the Public Advocate for Queensland I undertake systemic advocacy to promote and protect the rights and interests of Queensland adults with impaired decision-making ability. There are several conditions that may affect a person's decision-making ability. These included intellectual disability via brain injury, mental illness and neurological disorders such as dementia. I recently released a two-volume report on adult safeguarding in Queensland.

As I mentioned in my submission, one of the changes the bill we are discussing today proposes is to amend the Recording of Evidence Act and the Mental Health Act to facilitate the electronic recording of evidence before the Mental Health Review Tribunal, a development which I strongly support. As I mentioned in my submission, complete, accurate and accessible records of proceedings are fundamental in any legal proceeding, especially among a cohort of people who may be experiencing impaired decision-making capacity that could affect their recollection and perception of those proceedings. There would generally be no argument that the recording of a proceeding is a requirement in a fully accountable, transparent and fair system; however, the recording must also be accurate and complete.

I note in my submission that clause 35 of the bill appears to allow a judicial person prescribed by regulation the discretion of arranging for the recording or transcribing of a record under the Recording of Evidence Act, through the use of the word 'may'. It is my submission there should not be a discretion to record a proceeding. All Mental Health Review Tribunal proceedings should be electronically recorded unless there is a compelling reason not to do so, such as a strong degree of distress from the patient themselves about this. I said more about that matter in my written submission.

I also note that another change proposed in the bill concerns the Mental Health Act. Clause 15 allows a patient to waive their right to legal representation in other ways rather than exclusively in writing, which will allow the patient to do so orally, and the tribunal must be satisfied that this would not cause injustice to the person. I think that is a good development, as I said in my submission. My suggestion is to strengthen the bill in this regard by requiring that, if the waiver of the right to representation is done verbally, it should only be done in circumstances where there is a recording and transcription of such a waiver. In addition, the Mental Health Review Tribunal should be required to be satisfied that the patient has the requisite capacity to waive their right to representation; namely, that they understand the consequences of such a decision. This would ensure that the right to legal representation was waived by an individual who was fully aware of their rights and the consequences of not having representation before the Mental Health Review Tribunal were properly discussed. Thanks again for having me here today. I welcome your comments and questions.

CHAIR: To start, I would like some clarification around capacity of people in making decisions or people being before a hearing. To inform the committee can you give an idea of where you want a recording and some examples of where it might not be appropriate?

Dr Chesterman: I would move that discussion away from capacity as such and more into the realm of where this was causing distress to the person. If that were causing distress—the mental health system is designed to be therapeutic, so we need to be very cautious not to cause distress to a person unnecessarily. An instance would be if the person were likely to be distressed by a recording, that would be a compelling reason not to record it. That is where you would want to have a conversation with them about what they think would be appropriate. Otherwise, it should be a default. That would be my submission.

Ms KING: Thank you for your advocacy on behalf of people with impaired decision-making capacity. I am interested to have you explain in a bit more detail for the benefit of the committee the situations regarding privacy and access to transcripts of electronic recordings or the recordings themselves. What is the situation now? What would it be following the proposed amendments? Who can access recordings of these very sensitive tribunal hearings and under what circumstances in general terms?

Dr Chesterman: Historically, there has been some uncertainty and lack of fit between the privacy elements in the Mental Health Act and the Recording of Evidence Act and the application of the two together to Mental Health Review Tribunal hearings. The proposals in the bill will clarify that by amending both pieces of legislation. In the amendments to the Mental Health Act there are certain specifics regarding who could access the transcriptions or the recordings.

Ms KING: The person they are representing?

Dr Chesterman: That is right.

Ms KING: Their treating team under certain circumstances?

Dr Chesterman: I look to my colleague. I have the bill in front of me. There are provisions there that specify in new section 793A of the Mental Health Act, subsection (2) that an entitled person would be—it is quite limited.

Mr Matsuyama: It is effectively everyone who can receive notices. That can include the treating team as well because they are often responsible for things that happen in the tribunal proceedings. From my understanding people who are involved in that instance would be receiving the transcript.

Ms KING: I was interested to learn in the course of this committee inquiry that at present there is not a default electronic recording of proceedings and the reliance is upon the member taking—

Dr Chesterman:—notes.

Ms KING: Have issues arisen in the past regarding a need to refer back to those notes and perhaps in the heat of the moment them not being fully complete or not reflecting somebody's recollection? Are you aware of issues regarding that note-taking process?

Dr Chesterman: I know notes have been referred to. I am not aware of concerns about the accuracy of particular notes, although I do not doubt that has existed in the past. Of course we are talking about members taking notes; we are not talking about shorthand, which is a particular way of accurately recording—

Ms KING: It is the person who is responsible for making the decision also needing to record it as they go.

Dr Chesterman: That is right. There has long been advocacy from myself and predecessors in my role around the need to have full, accurate recordings because of the concerns that can arise around recollections and inaccuracy of notes or incompleteness of notes, which is more often the case.

Ms KING: I can well imagine that as evidence or submissions roll on, things could very readily be missed.

Dr Chesterman: Yes, indeed. We all know from our interactions that in a hearing like that you are wanting very much to engage with the person, and looking down and taking notes is not an easy way to enable that to occur.

Ms PEASE: Further to that, can other people in the room take notes as well? Does the person who is there or their advocate take notes, or is there no formal record of what takes place currently?

Dr Chesterman: In my view there would be nothing stopping someone taking notes.

Mr Matsuyama: Everyone is taking notes. As you can imagine, it is not dissimilar to say a courtroom where the lawyers are taking their own notes even though evidence is being recorded in a different sort of legal setting. Everyone is taking their own notes. I have certainly heard from individual advocates about inconsistencies between people's recollections as to what occurred. Without an electronic recording, there has been some dispute as to what witnesses have said, what has been said by their clients and what has been said by the tribunal. Those issues do certainly crop up.

Ms PEASE: I can imagine. You talk about it being similar to a courtroom, but one big flaw is that it is not recorded.

Mr Matsuyama: There is no actual master recording, so to speak, that everyone can refer to saying, 'That is actually what happened,' as opposed to everyone writing down the best they can in terms of note taking. Once you take notes there is certainly an interpretation of what people recall, what was actually said and trying to remember what was actually done.

Ms PEASE: I want to talk further about a non-verbal indication that they might not necessarily want legal representation. You talked about it being a good opportunity for people because they might feel threatened or uncomfortable and the most important thing is the good mental health of those

people. You talked about competency or being able to make those decisions. Is that review given at the time that this is taking place or prior? When is a decision made as to whether this person is competent enough to make a decision that they do not want legal representation?

Dr Chesterman: Capacity is something that is decision specific, so it ought to be assessed at the time the decision is being made. The broad expectations around capacity include that the person understands what the decision is, can retain information about it and can communicate the decision in some manner—it does not have to be spoken—and weigh up competing factors. That is what capacity is defined as. In this situation it is understanding the implications of not having representation. That has to be assessed at the time.

Ms PEASE: Who would assess that?

Dr Chesterman: The tribunal. That is—

Ms PEASE: The tribunal themselves?

Dr Chesterman: If the person were waiving their right to representation you would want the tribunal that is conducting the hearing to make that call.

Ms PEASE: Would there be an advocate on behalf of that person before the tribunal that is with them?

Dr Chesterman: There could be.

Ms PEASE: That advocate is not considered to be a legal representative; it is just someone who is there as a support person?

Dr Chesterman: Yes, that is where you would want to go to the individual themselves and make sure, 'You want this person, but you don't want a lawyer?' In that situation you would want to clarify that that is their wish and they understand what they are doing in making that call.

Ms PEASE: Again, at the moment that is not recorded?

Dr Chesterman: It is not required to be. In fact, at the moment it has to be a written waiver.

Ms PEASE: Who would write that? The tribunal themselves?

Dr Chesterman: The person would have to.

Mr O'CONNOR: The reason you put in that comment about more expressly stating where electronic recordings should not occur if there are compelling reasons, distress and that sort of thing, the ultimate aim is that in as many cases as possible you should have an electronic recording as a record of what has actually happened?

Dr Chesterman: Yes.

Mr O'CONNOR: Particularly in those distressing situations? That is why you want it a bit clearer?

Dr Chesterman: That is right. We want the default position to be that there would be an electronic recording. You would have to say some circumstances largely would be around the therapeutic area where the person is substantially distressed; that is when you want to make an exception but be quite specific about those exceptions.

Mr O'CONNOR: Would that not be a situation where you would want a recording? It depends on the distress I guess.

Dr Chesterman: Just to clarify, it would not be that the person is distressed about the hearing; it is that actually recording it is the cause of the distress; that is what we want to specify in that matter. Oftentimes people will be distressed in a hearing circumstance; it is not the recording that is causing the distress.

Mr O'CONNOR: You made another point about when someone might waive their right to legal representation. Were you calling for that specifically to be outlined in the bill that when someone does that it must be electronically recorded?

Dr Chesterman: The preference would be for that to be recorded. That is just so everyone is clear that the person has waived the right because there would no longer be a written record—and there are good reasons for moving away from requiring it to be written. We want to make sure that that is recorded somehow and not simply a matter of someone's recollection that the person orally waived their right to representation.

Ms KING: I have a couple of short questions. I am not certain whether it was in your submission or perhaps one of the disability peak bodies. Somebody made a comment about the requirement at present for a written waiver of representation in proceedings creating delays or barriers.

Dr Chesterman: Yes, I certainly know that argument. Did we put that in?

Mr Matsuyama: No. I believe it might actually be in the explanatory notes as to the reason why the amendment is being made. In terms of a delay, I can certainly see that happening in a sense that if the patient wanted to waive their right to have a representative and for some reason that cannot be arranged, then the entire proceedings would have to be adjourned until such point that a written waiver could be made. I have not personally seen or heard of a situation of that happening but I can certainly see that happening, for example, if the patient is participating over the phone or through a video link and there is no way to hand them a piece of paper which might contain a waiver.

Getting rid of written waivers does make sense, but our submission is there should be a proper and full record as to that happening just so that in the future if that person or their representative is looking back to figure out why they did not have representation, the full record is there.

Ms KING: In respect of electronic recordings of proceedings versus transcripts, do you have any submission to make about the importance of written transcripts being provided or is it in your view sufficient that access to electronic recordings could be provided? In my work as an MP I know that I do not always have time to sit through hours of an electronic recording of a proceeding like this one. Flicking through a transcript can be more accessible in some circumstances.

Dr Chesterman: Sure and for accessibility reasons I would argue that where a person, for instance, who is the subject of a hearing requests a transcript, that ought to be able to be provided for those accessibility reasons.

CHAIR: That concludes this session. Thank you very much for your submission and your time before us today.

Dr Chesterman: Thanks very much for having us.

KOPILOVIC, Ms Chloe, President, Queensland Law Society

THOMPSON, Dr Brooke, Senior Policy Solicitor, Queensland Law Society

WILLIAMS, Ms Karen, Deputy Chair, Health and Disability Law Committee, Queensland Law Society

CHAIR: I now call representatives from the Queensland Law Society. Welcome. This is a good segue following the Public Advocate around your submission and concerns about the bill. Would you like to make an opening statement?

Ms Kopilovic: Thank you for inviting the Queensland Law Society to appear at this hearing this afternoon. In opening, we would like to recognise the traditional owners of the land on which this meeting is taking place, in both the Turrbal and Jagera nations, and pay respects to all elders past, present and future. Today our submission is confined to the bill's amendment of the Recording of Evidence Act and the Mental Health Act.

Electronic recording and the availability of transcripts across all Queensland courts and tribunals is a fundamental element of conducting contemporary proceedings. We are very supportive of the bill's intention to facilitate the Mental Health Review Tribunal implementing an electronic recording and transcription service. However, we do recommend that the bill be amended to ensure that there is no discretion to record a proceeding. The tribunal should be required to record a proceeding unless there is a compelling reason not to do so. This requirement should be explicitly stated in the legislation.

We also recommend changes to clause 15, which provides that a person may waive their right to representation verbally if the tribunal is satisfied it would not cause injustice to the person. Given the importance of legal representation for persons who are appearing before the Mental Health Review Tribunal, we recommend that a verbal waiver must only be allowed where there is a recording and transcription of the waiver. In these circumstances, the tribunal should also be required to be satisfied that the person has capacity to waive their right to legal representation.

Today I am joined by Karen Williams, the deputy chair of the Queensland Law Society Health and Disability Law Committee, and Dr Brooke Thompson, a senior policy solicitor with the Queensland Law Society. We welcome any questions the committee may have.

CHAIR: This is an interesting segue, as I stated, given the Public Advocate just commented very similarly. I think your wording was that, unless there are exceptional circumstances, it should be recorded, and that is the area the Public Advocate landed on as well. Could you give an example here? The Public Advocate used the example of where it causes distress. I am interested in the capacity side of things.

Ms Kopilovic: I will defer to the subject matter experts.

Ms Williams: I will start and Brooke can fill any gaps that I may miss. I think distress is too low a bar still. It would have to be significant distress, because within the mental health tribunal there are often clinicians and case managers and people who are well skilled and well versed in settling the mental health clients. They have their lawyer who would have spent some time going over the material. It is about significant distress rather than distress per se. The Public Advocate really brought that tight focus that it is around the actual recording of the hearing, not just generalised distress about the hearing. The tribunal will make that decision. They can be informed, as they are, all the way through their processes about asking questions of the treating doctor and the treating team as to what advice they have on that particular matter.

Dr Thompson: I do not have anything further to add to that, but I agree with what Karen said. It does go to the point of the person being distressed about the actual recording of the proceeding and the fact that they may then disengage from the hearing completely if the hearing takes a turn and it becomes all about that issue of recording. People are distressed all the time about court proceedings and those proceedings being recorded, but in all those other circumstances that is really not a consideration that is taken into account. Here we would argue that the person would need to be significantly distressed about the actual recording and not the hearing itself.

CHAIR: Are there any questions, or do you think it was covered?

Ms KING: I think it was fairly well covered, but I will inquire whether to your knowledge this issue of distress about the recording of proceedings is a routine feature that crops up in the Mental Health Review Tribunal setting. Is this something that many people indicate, or is it simply that it has been used as an example of where there might be a compelling reason to make an exception and then we are going on to discuss the ins and outs of this particular example that has been given?

Ms Williams: It has not, because recording of evidence has not been a feature. There was a project undertaken some time back, and I am not aware that it became a compelling reason not to progress with recording of evidence. It is hard to know and people are very sensitive, according to the people appearing before the tribunal and their needs. On the flip side of that, there are also issues about building trust in the system and showing independence and accountability. There are a lot of positive things in our view that can come out of it, apart from the possibility of some people being extraordinarily distressed about the actual recording. We all walk out of the room with different perceptions that we cannot actually put our finger on that that is actually what happened.

Ms KING: You mentioned there was a trial of recording of proceedings previously. I have not encountered that.

Dr Thompson: The Mental Health Review Tribunal did a short trial a couple of years ago where they had the tribunal members record the proceedings with whatever recording device they were provided with. They produced a short report with some results of how the tribunal members thought the trial went. One of the issues that was brought up was there were difficulties with some patients not wanting the hearing recorded. I believe in the vast majority of the cases that were included in that trial there were no real issues with recording.

CHAIR: It might be a benefit to the committee if we could get that report.

Dr Thompson: I can send the committee that report.

CHAIR: That would be fantastic.

Ms PEASE: Would there be any other factors as to why people before the tribunal would not want to be recorded, apart from distress?

Dr Thompson: There are probably a whole range of reasons why some people do not want a hearing recorded.

Ms PEASE: We seem to be honing in on that one thing—that it is causing great distress for them. I imagine for people who do have some mental health issues there might be concerns about the trust and where the information is going to go. Could you imagine there would be any other reasons as to why we could justify not recording it?

Dr Thompson: It could also be the actual recording equipment. We have been told the tribunal have hearings in various places, so it could be if the equipment is not adequate or the environment is not adequate for a recording. I think the main reason would be the impact on the person who is the subject of the hearing. Our submission is simply that the default position should be that there is a recording.

Mr MOLHOEK: Could you describe what a hearing would look like? Is it in a very formal setting like this, or is it in a consult room with just a few people sitting around?

Ms Williams: It varies. Pre COVID times it would be a meeting room in a hospital and there would be some tables, which would sometimes be set out in a square arrangement. The tribunal consists of three members. Pre COVID it would be in person, with the person and their support people, which could be family, and whether they are entitled to a lawyer or legal representation. There would often be the Attorney-General's rep in that type of matter who would be on an audiovisual link. There is also the treating team, which may be one person or several people depending on the matter. The timing might go from 45 minutes to an hour and a half.

The legal member would get proceedings underway and then ask if any of their fellow tribunal members wanted to ask particular questions of the doctor. If the person is there, they will make sure they feel comfortable straightaway. That is ordinarily what happens. Sometimes they will say to the legal members if the matter is a bit more contentious, 'Is there anything you want to bring to our attention straightaway? Has everyone got all of the material?' and things like that.

Now with COVID, we are on phones, we are on audiovisual, everyone is in different places. It is done differently. The person would usually still be in the mental health service, which is where the room would be.

Mr MOLHOEK: What sorts of matters would the tribunal typically deal with?

Ms Williams: It is a range of matters. There are treatment authority matters. The person might be a younger person who for the first time finds themselves having to deal with a possible diagnosis of a severe type of mental illness and they are not willing to engage in treatment. It could be someone who has been under a treatment authority for several years and they are returning to the tribunal. It could be someone for an ECT application so they have been extraordinarily depressed or had treatment resistant illness. It could be someone on a forensic order looking at quite specific conditions

of the order—whether they progress from hospital to community and then when in the community whom they can visit, what they can do, where they can go, where they can live, that type of thing. Does that help?

Mr MOLHOEK: That is helpful. In terms of recording those sessions, I assume sometimes they are in a formal setting where the facility is set up to do that and then on other occasions there are perhaps more ad hoc arrangements or facilities used. Does a specialist in recording have to be engaged? We have Hansard here today, but who does that recording and where does the equipment come from? Is it hired or is it permanently set up? What are the logistics around that?

Dr Thompson: The Queensland Civil and Administrative Tribunal also conduct some of their hearings in hospital settings and they record all of their proceedings. It is my understanding that they have people specifically employed to do more of that administrative work, whereas I do not think the tribunal has a lot of administrative assistance so it does fall often to the tribunal members to make sure that everybody has dialled into the hearing, that people are on video link and that the recording device works. That was something raised in the report of that short trial of recording—that it does fall to the members to have to deal with to make sure the equipment actually works. When you only have 30 minutes for a hearing, you are the legal member, you have to take notes, you have to give reasons and you have to deal with the treating team, it becomes a lot to do.

Mr MOLHOEK: You have to make sure people are within the range of microphones and other things as well.

Ms Williams: Because so much happens over the phone and on audiovisual, we are often moving the microphones around the table. Sometimes there is some level of support from the health setting but that varies across the health services. People are regularly in the one room and the trick is often whether the audiovisual link is working et cetera.

Mr MOLHOEK: Usually the best laid plans of mice and men fail when it comes to recording.

CHAIR: I think it is timely to acknowledge Hansard and the very different environments that they work in when recording various public hearings.

Mr O'CONNOR: In addition to the electronic recordings, your submission talked about the availability of transcripts. Is that related to the nature of these hearings, to make it easier for both the person attending or appearing at one of those hearings as well as their legal representation to have an available transcript of what was in the electronic recording?

Dr Thompson: At any hearing, as the person subject of an order you can be given specific conditions attached to your order and it can be obviously very helpful for a person or their legal representative or a support person to have a copy of the transcript so you can actually be very clear on what was said and what you were directed to do or not do.

Mr O'CONNOR: Instead of playing it back on a video, I guess?

Dr Thompson: Or not having any more official recording of exactly what was said. The other issue, and Karen can probably speak to this more, is that the tribunal is constituted of different members every time it sits. You might appear before the tribunal and that tribunal will be comprised of three members and then you go back in six months time for a review and the tribunal will be comprised of different tribunal members. At the moment they do not have access to any recording or transcription of what happened in the last hearing. You have to repeat things and start over again each time you do appear. We think that having a transcript available would not only assist the person appearing but also the tribunal members in knowing what has been done previously.

Mr O'CONNOR: And your recommendation would be that this bill say that the transcription must be provided in addition to the electronic recording?

Dr Thompson: I think our position is more so that the default position should be that everything should be recorded and that if you want a copy of that transcript you should be entitled to get a copy.

CHAIR: Member for Mirani?

Mr ANDREW: No, that satisfies what I was going to ask, thank you.

CHAIR: We thank the representatives from the Queensland Law Society for being here today and for your contribution.

HOLMES, Ms Neroli, Deputy Commissioner, Queensland Human Rights Commission

LEONG, Ms Rebekah, Principal Lawyer, Queensland Human Rights Commission

CHAIR: I now welcome representatives from the Human Rights Commission. I thank you for your submission. Would you like to start with an opening statement before we move to questions?

Ms Holmes: Thank you very much for allowing us to appear today. I first acknowledge the traditional owners of the land on which we meet today and pay respects to elders past, present and emerging. We actually do not have a large submission to make to the committee. One of the major things that we have addressed has been well dealt with.

The commission's submissions on this bill are confined to amendments relating to the recording of the Mental Health Review Tribunal proceedings. The commission supports the electronic recording of such proceedings, protecting a person's rights to a fair and public hearing and the right to recognition and equality before the law. The limits imposed by the bill on the disclosure of recordings are appropriate for the protection of an individual's right to privacy.

The commission commends the Mental Health Review Tribunal's commitment to electronically recording all their proceedings. The commission's only concern is that, under the amendments, the tribunal will maintain discretion on whether to electronically record proceedings rather than having a legislative requirement do so. However, the commission acknowledges that any amendment to the Recording of Evidence Act in this way would need to carefully consider the implications on other tribunals that also have obligations under this legislation. We really do not have much more to say to the committee other than that.

CHAIR: Thank you very much. Prior to your arrival, we heard from representatives from the Queensland Law Society and the Public Advocate. Both spoke around exactly the same issue. Our questions largely were about what would be considered exceptional circumstances so that the recording of information would not be appropriate. Can you provide some idea of what those exceptional circumstances might look like? We had slightly different views from the Public Advocate and the Queensland Law Society. I would be interested to hear what your definition is.

Ms Leong: The Mental Health Review Tribunal is a therapeutic jurisdiction and it is dealing with people who have mental illness. At the same time, though, those people with mental illness have a right to equality and we would expect in any other judicial or legal proceedings that those matters would be recorded no matter the person involved, for the protection of their hearing.

I would expect that exceptional circumstances in the Mental Health Review Tribunal would hardly ever exist. I think if a person has an awareness that the matter is to be recorded and it is done as of course and it has nothing to do with them but is a part of normal due process of these legal proceedings or it will be a change—if they have gone to repeated Mental Health Review Tribunal proceedings, it might be a new thing to be recorded. As long as they are properly briefed beforehand and had it explained to them, I cannot imagine there would be many circumstances in which they would refuse to have those proceedings recorded. Also an understanding of where that recording goes; that it is not just a matter of public record but it is very much confined to certain parties who can get access to that recording.

CHAIR: I will open up to questions. I know we have canvassed this topic.

Ms KING: You made a comment in your opening statement that the provision of a requirement to record rather than the proposed discretion to record would require changes to the Recording of Evidence Act and that might have implications for other tribunal proceedings. Could you unpack that for me a little so I understand it?

Ms Holmes: I am not sure what they would be but that was, I think, what the department put in their response to our issues that were raised. I must admit I do not think we considered that—

Ms KING: I was confused by it when they said it.

Ms Holmes: We were thinking strictly, when we wrote our submission, about the Mental Health Review Tribunal. We were not turning our minds to other tribunals. Unless Rebekah has some ideas, that might be a question—

Ms KING: That might be something for me to inquire of the department, who are presenting following your time with us.

Mr MOLHOEK: We heard from the Law Society about, I guess, the convenience of recording and then having a transcript of perhaps the recommendations of the tribunal or advices that were given. Beyond the therapeutic purposes of the tribunal and trying to help people and make better

decisions, could these recordings and transcripts become the basis of, say, legal appeal? Could they be drawn on at a later stage by a disgruntled family member or individual and then used in a court to prosecute other matters or matters of fairness or equity around that?

Ms Leong: I think there are pretty strict provisions under the Mental Health Act about what information can be used that is disclosed in Mental Health Review Tribunal proceedings. Certainly the transcript itself will only be able to be disseminated to certain parties. I think those parties themselves are also under confidentiality obligations. I am speaking off the top of my head so that might need to be checked with the relevant experts on that issue.

Certainly the transcript would be useful for a patient. It is quite an emotional and stressful environment, so the ability to be able to perhaps listen to that recording in a safe, less stressful environment might help them understand why the tribunal made the decision as they did. It could also support the tribunal in preparing written reasons to make sure that they got the facts right. I understand they listen to a number of hearings in a day. That can be, I am sure, a useful tool to remember what was said at a particular hearing. Certainly if you are going to appeal a decision from the Mental Health Review Tribunal to the Mental Health Court, both having a statement of reasons as well as a transcript could be useful to the parties.

Mr MOLHOEK: Do you have any concerns about areas where that information or those transcripts could be abused or misused?

Ms Holmes: My understanding is that it is very strict on who can access the transcript and who cannot and that is very well regulated by the tribunal itself under its own rules of procedure. It is not like a normal open court process where you are allowed to request copies of transcripts if you pay for them generally to look at what went on and review what went on in hearings. It is a therapeutic process and quite a closed process, which is protective of the patient. I guess that is why we think it is important that it be recorded so that they can recall and everyone can recall, who has a relevant interest, to know what happened and what has gone on and to be able to review it. I do not think that we have had any concerns that inappropriate use of it could be made by people who are not intimately involved in that process.

Mr MOLHOEK: If one were a bit paranoid you could understand why people would have concerns about it being recorded and maybe used against them.

Ms Holmes: Are you talking about the patient themselves?

Mr MOLHOEK: Yes.

Ms Holmes: Possibly. We are coming from a premise of equality before the law. Every time you have a major imposition on your rights as a person—and being detained without choice is a major imposition on your human rights—knowing the reasons for that and having them transparently recorded for your future knowledge and use if you want to challenge it or if you want to review and understand it we think is a precautionary thing. Obviously, people who are unwell might sometimes be paranoid about recordings and have those concerns and fears. The underlying premise of where we are coming from is that it is really important for the protection of rights that proceedings are transparent and done in an appropriate way and that a record of the evidence is kept for such a big decision as a supervision or detention order.

Mr MOLHOEK: The interpretation of that evidence down the track could be challenging. I suspect some people in that setting might be inclined to make statements because of their ill health at the time that, when listened to, could be quite disturbing and really not intended but just poorly articulated. Is there a risk that could be used against them at some future point? Do you think the restrictions on the use of that information are tight enough and that it could be retained only for therapeutic analysis, whether that has been fair and reasonable, as opposed to being taken advantage of in some other way?

Ms Leong: Again I am speaking off the top of my head, but I think there are fairly strong privacy protections under the Mental Health Act already existing around the issue of maintaining the patient's privacy. There is material produced for the hearings themselves, and those are subject to privacy and confidentiality. We would assume that the transcripts and these recordings would be subject to the same protections. I assume until now those protections have been sufficient. If they cover the transcript as well then there would be some risk, but it would be a proportionate risk.

Mr MOLHOEK: I am just thinking a bit beyond those circumstances perhaps into other areas such as domestic and family violence or control. Hypothetically, if someone was given the transcript of the recommendations and took it home with them, someone else could read it and use it against them to manipulate them in some way. I guess that is a risk in any circumstance, but I am just curious as to whether—

Ms Holmes: If the patient inadvertently let the transcript go to someone who might use it in—

Mr MOLHOEK: Just leave it on the sideboard at home and then someone else decides to have a read.

Ms Leong: I think that is the same risk anywhere. If you are talking about recommendations made by the tribunal, a person is still entitled to the written order made by the tribunal.

Mr MOLHOEK: So that is still a risk.

Ms Leong: It is still the same risk.

Mr MOLHOEK: Thank you. I was just trying to understand.

Ms PEASE: I just want to explore something a little bit further. In your response to one question, Rebekah, you said that you could not see why someone appearing before a tribunal would object to it being recorded. We heard earlier today from one of the presenters that it could cause great stress. You did mention building trust and it being like a normal court proceeding. You may or may not have heard the other presenters from the Public Advocate and the Queensland Law Society who talked about that level of discretion. In light of that, off the top of your head would you consider there may be reasons why a person with a mental health condition may feel it stressful to have it recorded, and could that be valid? Would it be an infringement of their human rights if we took that away from them?

Ms Leong: I am not a mental health clinician. I imagine that if a mental health clinician says, 'This person is so distressed that the damage or trauma caused to them or their mental health outweighs the value in them having an electronic recording of their proceedings,' then that might be a scenario where you would defer to clinical advice. If you are balancing out rights, the safety and wellbeing of the individual probably outweighs a recording which goes towards a fair hearing, but there are other aspects of a Mental Health Review Tribunal hearing that support a fair hearing.

Ms PEASE: Given the protections for people appearing before the tribunal, does having a recording weigh more heavily on their human rights than their decision that they do not want it to be recorded because it impacts on their mental health? What is more important?

Ms Leong: Their autonomy and their ability to make the decision whether or not they want it recorded? If they have capacity—

Mr MOLHOEK: It is a dual-edged sword.

Ms Leong: I am not sure I can answer that. We certainly do not have that choice in other legal proceedings. It is just recorded because it is recorded. Even if you have full capacity and you say, 'I don't want this recorded,' there is not that choice in other courts.

Ms KING: They are often made public too.

Ms PEASE: Is that then a breach of their human rights? Let's not go down that path today.

Ms Leong: I would have thought that, by analogy, a request not to record—actually, I do not think I can take it any further.

CHAIR: Thank you both very much. That concludes this part of the hearing. We do appreciate representatives from the Human Rights Commission coming before us. It has been insightful. This public hearing is now closed.

The committee adjourned at 12.52 pm.