HEALTH AND ENVIRONMENT COMMITTEE

Members present:
Mr AD Harper MP—Chair
Mr R Molhoek MP
Mr SSJ Andrew MP (virtual)
Ms JE Pease MP
Dr CAC Rowan MP
Mr TJ Smith MP

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

PUBLIC BRIEFING—INQUIRY INTO THE PUBLIC HEALTH AND OTHER LEGISLATION (COVID-19 MANAGEMENT) AMENDMENT BILL 2022

TRANSCRIPT OF PROCEEDINGS

WEDNESDAY, 28 SEPTEMBER 2022

Brisbane

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The committee met at 9.30 am.

CHAIR: Good morning everybody. I declare open this public briefing for the Health and Environment Committee's inquiry into the Public Health and Other Legislation (COVID-19 Management) 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 people whose lands, winds and waters we all share.

With me here today are: Mr Rob Molhoek, the member for Southport and deputy chair; Mr Stephen Andrew, the member for Mirani, who is joining us via teleconference; Ms Joan Pease, the member for Lytton; Mr Tom Smith MP, the member for Bundaberg, who is substituting for Ms Ali King MP, the member for Pumicestone; and Dr Christian Rowan MP, the member for Moggill, who is substituting for Mr Samuel O'Connor MP, the member for Bonney.

On 1 September 2022, the Hon. Yvette D'Ath MP, the Minister for Health and Ambulance Services, introduced the Public Health and Other Legislation (COVID-19 Management) Amendment Bill 2022 into the Queensland parliament. The bill was referred to the Health and Environment Committee for detailed consideration and report. The briefing today by officials from Queensland Health and Queensland Corrective Services is to explain the objectives and key provisions of the bill.

The committee's proceedings today are proceedings of the Queensland parliament and subject to the parliament's standing rules and orders. Witnesses are not required to give evidence under oath, but I remind witnesses that intentionally misleading the committee is a serious offence. I also remind committee members that officers are here to provide factual or technical information. Any questions seeking an opinion about policy should be directed to the minister or left to debate on the floor of the House.

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 also appear on the parliament's website or social media pages. Please turn your mobile phones off or switch them to silent mode.

GERRARD, Dr John, Chief Health Officer, Queensland Health

HARMER, Mr David, Senior Director, Social Policy, Legislation and Statutory Agencies, Queensland Health

HUMPHREYS, Mr Tom, Acting Assistant Commissioner, Professional Standards and Governance Command, Queensland Corrective Services

JOLDIĆ, Ms Jasmina PSM, Associate Director-General, Strategy, Policy and Reform Division, Queensland Health

MAHLER, Mr Karson, Manager, Legislative Policy Unit, Queensland Health

CHAIR: I now welcome Chief Health Officer, Dr John Gerrard, and policy officers from Queensland Health—Ms Jasmina Joldić, Mr David Harmer and Mr Karson Mahler. I also welcome Mr Tom Humphreys, Acting Assistant Commissioner, Professional Standards and Governance Command, Queensland Corrective Services. I invite each group to make an opening statement, perhaps starting with Queensland Health.

Ms Joldić: Chair and members of the committee, thank you for the opportunity to brief you about the Public Health and Other Legislation (COVID-19 Management) Amendment Bill 2022. I would like start by respectfully acknowledge the traditional custodians of the lands on which I am speaking to you today, the Jagera and Turrbal people, and pay respect to their elders past, present and emerging. I am Jasmina Joldić, Associate Director-General of Queensland Health. I am joined

today by my colleagues—Dr John Gerrard, Chief Health Officer; Mr David Harmer, Senior Director, Social Policy, Legislation and Statutory Agencies Branch, Queensland Health; and Mr Karson Mahler, Manager Legislative Policy Unit, Queensland Health.

Before providing an overview of the bill, I would like to thank the individuals and organisations that have made submissions to the committee's inquiry and that will be appearing before the committee today. Many of the stakeholders also provided input to Queensland Health during the development of the bill. Their contributions have helped us to assess the potential impacts of the legislation for different parts of the community and to ensure the proposed approach is balanced and well considered.

I will now provide a brief overview of the bill. Since March 2020 Queensland's public health response to COVID-19 has been authorised by temporary amendments to the Public Health Act 2005. The temporary emergency framework provides broad powers for the Chief Health Officer and emergency officers to prevent and respond to the spread of COVID-19 in the community. These emergency powers have been integral to Queensland's successful pandemic response.

Until Queensland's borders reopened in December 2021, the emergency powers were used to effectively prevent the spread of COVID-19 within Queensland and control outbreaks when they occurred. This allowed Queenslanders to largely continue activities of daily life despite an ongoing global pandemic. While the emergency legislative framework has served us well, the current pace of the pandemic requires a different approach. We are no longer focused on containing or suppressing the virus. Instead, we are living with it while carefully monitoring and managing its impacts on the health system and community. This does not mean that it is appropriate to end all public health measures.

On 15 September 2022 the World Health Organization cautioned that, while the end of the pandemic is in sight, governments should remain vigilant and continue to use appropriate infection control measures to manage the ongoing risk of COVID-19. In this context, it is appropriate to revisit the current legislative framework and consider what measures remain necessary to manage COVID-19 when the current legislation expires. It is proposed to allow the emergency framework to expire as scheduled on 31 October 2022.

If enacted, the bill will replace the emergency framework with limited measures to manage COVID-19 as a notifiable condition in the Public Health Act without the need for a public health emergency to be declared. The new temporary amendments in the bill will sunset on 31 October 2023. This will provide a step-down approach by continuing necessary measures to manage serious risk and maintain a nationally consistent approach. This step-down approach recognises that individuals are taking more responsibility to self-manage COVID-19 as time goes on with government only stepping in where necessary to preserve the health and safety of Queenslanders and the public health system.

I note there was strong stakeholder support for replacing the current emergency legislative framework with more limited powers to manage COVID-19 as a controlled notifiable condition outside of a declared public health emergency. The bill provides an enabling framework. It enables but does not require directions to be made. If the risk remains stable, the power to give directions about particular matters may not be needed to be exercised. However, if the risk of COVID-19 rises to a point of serious risk to the community or the public health system, this framework enables the Chief Health Officer to make proportionate and tailored directions to manage the threat.

In contrast to the current emergency legislation, the bill provides a much more limited power for the Chief Health Officer to make public health directions. Directions may only be made about masks, isolation for people diagnosed with COVID-19 and quarantine for symptomatic close contacts, and vaccination for workers in specific settings. These are the targeted measures currently in place and most likely to be needed to manage the risk of COVID-19 for the next 12 months.

The Chief Health Officer will not be able to close Queensland's borders, institute lockdowns or impose other restrictions on movement and gatherings. The bill revises the threshold for when the Chief Health Officer may exercise the directions power to when it is reasonably necessary to do so, including to prevent or respond to a serious risk to the public health system or the community as a result of COVID-19 or to give effect to COVID-19 advice from national bodies or a decision from National Cabinet. This amendment is consistent with the current public health focus on managing COVID-19 within the community rather than seeking to contain or suppress it.

The bill also inserts a range of safeguards to enhance transparency of decision-making and to ensure appropriate parliamentary scrutiny of public health directions. For example, the bill requires directions to be tabled in parliament within 21 days of being given and referred to the relevant

parliamentary committee for review in the same way as subordinate legislation is. Directions will also be subject to disallowance by parliament. Directions must be accompanied by a statement justifying their rationale and compatibility with human rights. This justification statement must be published on Queensland Health's website and tabled in parliament with the direction.

Public health directions will expire after 90 days unless they are revoked before that time. This will require the Chief Health Officer to regularly review directions to ensure they are only remain in place if needed. The enforcement of directions is expect to be limited to very serious breaches and will be carried out by authorised persons appointed under the Public Health Act. An offence provision is included for persons who contravene the public health direction and may be enforced through a penalty infringement notice.

The bill also temporarily extends amendments made to the Corrective Services Act 2006 to support the continued management of COVID-19 in correctional facilities. Corrective services facilities are uniquely vulnerable to the spread of COVID-19 due to the close proximity of prisoners and staff, the transience of prisoners and staff in and out of the facilities and the limited ability to maintain social distancing and other controls. A baseline level of controls is still required to manage these risks. As the amendments to the Corrective Services Act fall under the administrative responsibility of Queensland Corrective Services, we are joined here today by Tom Humphreys, Acting Assistant Commissioner, Queensland Corrective Services, who will be happy to answer any questions about this aspect of the bill.

In concluding, I acknowledge that not all stakeholders support the proposed approach in the bill. We know that there are strong views about the government's role and powers in relation to COVID-19. We also acknowledge that states and territories have taken different approaches based on their specific circumstances and existing legislative frameworks. Ultimately, it is a matter for parliament to determine the best model for Queensland. With that said, we consider this bill strikes an appropriate balance between supporting Queensland's transition to living with COVID-19 while ensuring that the government can continue to manage the impacts of COVID-19 on the health system and the community. With the agreement of the chair, Dr Gerrard would also like to make a short opening statement in relation to the matters before the committee. We will then be happy to take questions.

CHAIR: Thank you very much. Please proceed Dr Gerrard.

Dr Gerrard: I would also like to acknowledge the traditional custodians of the land on which I am speaking to you today and pay my respects to their elders past, present and emerging. I am Dr John Gerrard, Queensland's Chief Health Officer. I am pleased to speak to you about the bill which seeks to continue the necessary measures to manage COVID-19 for the next 12 months as Queensland transitions to living with COVID-19. Queenslanders are now beginning to live with COVID-19. People, businesses and industries are adapting to self-manage the risks of COVID-19.

Since the opening of Queensland's borders in December of last year, Queensland has managed multiple waves of COVID-19 infection while maintaining health system capacity and protecting vulnerable members of our community. This success has been possible due to high rates of COVID-19 vaccination across the eligible population. We are at a point where it is appropriate to amend our regulatory framework to better reflect the transition we have made from the containment and suppression strategies used earlier in the pandemic to our current approach of living with COVID-19. The proposed amendments will maintain our ability to respond quickly to protect the most vulnerable members of the community if needed and ensure health system capacity can be maintained.

At this point in the pandemic I believe only targeted measures are required to manage the ongoing risks of COVID-19. COVID-19 continues to present a serious public health risk to our community and health system. We do not know what the future holds but we do know that new variants may emerge and that immunity wanes over time. As such, it is generally believed that further waves of COVID-19 infection may occur for some time.

Our recent winter period was a prime example of how COVID-19 can have a cumulative impact. At the peak of the most recent wave, on 25 July 2022, there were over a thousand people in public and private hospitals, with 28 in the intensive care unit. During this same period there were 35 patients in hospital with influenza. This increase caused considerable pressure on our resilient but fatigued health system and health workforce who continue to work tirelessly to protect Queenslanders. Individually these factors are manageable but collectively they can have serious consequences for the community and for the public health system.

As the associate director-general has explained, the bill enables directions to be issued about three things: masks, isolation and quarantine, and vaccination requirements for workers. These are the measures that have the highest impact on protecting our vulnerable cohorts within the community and preserving hospital system capacity. It is these measures that have kept Queenslanders safe and mitigated the impact on the health system during the last three COVID-19 waves.

Mask wearing is a highly effective way of reducing the risk of transmission of COVID-19 in areas where physical distance is not possible. Isolation for positive cases and quarantine for close contacts with symptoms continue to be crucial to prevent those at the highest risk of spreading the virus from moving within the community, putting others at risk and increasing strain on the healthcare system.

Limiting the period for isolation and quarantine to a maximum of seven days is consistent with Queensland's current approach to managing diagnosed cases and close contacts. It is also based on national guidelines developed by the Australian Health Protection Principal Committee and the Communicable Diseases Network Australia.

Vaccination has proved to be an important factor in protecting the community, especially for vulnerable cohorts. The ability to issue a direction to require workers in particular settings to be vaccinated may be necessary to support continuity of care and to protect vulnerable cohorts like people with disability and residents in aged-care facilities.

COVID-19 vaccine research is ongoing, including development of Omicron-specific vaccines. If the AHPPC or the Australian Technical Advisory Group on Immunisation were to recommend additional doses for particular workers in the future, the bill would enable direction to be issued to give effect to this national expert advice and ensure consistency with other states and territories.

The targeted measures in this bill provide a step-down approach to safely transition Queensland to living with the risks of COVID-19 while maintaining the ability to respond proportionately and in a tailored manner to COVID-19 risks as they emerge.

Under the bill, the Chief Health Officer can issue a public health direction to give effect to advice from national bodies such as the AHPPC or a decision of National Cabinet. Without this power, Queensland would have no mechanism to implement national advice and ensure that our state remains consistent with the national COVID-19 response.

The power may be used over the next 12 months, for example, to ensure Queensland's approach to isolating persons with COVID-19 remains consistent with other jurisdictions. The bill enables the Chief Health Officer to issue a public health direction if it is reasonably necessary to prevent or respond to a serious risk to the public health system or to the community. At this time I do not expect that these powers will be used often, or possibly at all, but it is important that Queensland has the ability to respond immediately if required, if something unexpected happens or the cumulative effects of successive wave of COVID-19 create a serious risk to the community.

I appreciate the community may be interested to understand what I consider constitutes a serious risk to the community or the public health system might be. The bill leaves this decision open to the Chief Health Officer to determine on a case-by-case basis. This reflects the process that I go through in determining when public health directions are required. There is no simple formula that determines when I as Chief Health Officer consider protective measures are needed. Rather I am continually assessing a range of epidemiological data, the likely efficacy of existing protective measures, expert advice from national bodies, community behaviour and public health system impacts.

In terms of serious risk to the public health system, I expect that I would be considering matters like the number of hospital beds occupied by COVID-19 patients, ICU numbers and staff furlough numbers to determine if the threshold of serious risk is met. For example, if the number of staff furloughed as a result of COVID-19 means that our ability to provide critical healthcare services is under threat, I may consider that particular directions are necessary.

A new variant may also pose a serious threat both to the community and to the public health system. This could include, for example, a new variant with high immune escape and/or high mortality rate. If such a variant were to emerge, it may be necessary to impose public health directions to protect the Queensland community. I hope this information is of assistance and I am happy to take any questions.

CHAIR: Thank you very much, Dr Gerrard. Mr Humphreys, did you want to make an opening statement?

Mr Humphreys: My colleague from Queensland Health addressed the Corrective Services Act amendment, so I am happy to hand back to the committee.

CHAIR: Before we go to questions, I think it would be remiss of this committee, who has handled several extensions of the COVID legislation from the start, not to recognise the extraordinary and remarkable work of every single Queensland Health worker over the last two years—just over two years—in managing fever clinics and ensuring that people get vaccinated wherever they are throughout Queensland. I take your words about fatigue and the extraordinary pressure placed upon our health workforce, but they are to be commended for their extraordinary work. I am sure everyone on this committee agrees with that.

Mr MOLHOEK: I echo the sentiments expressed by the chair without going into the same lengthy dialogue. The efforts of Queensland Health and other services like Corrective Services are appreciated. I am sure it has been a very challenging time. My question is to Dr Gerrard. If we cast our mind back to January-February 2020 when this health emergency was emerging and there was so little known about it, how do these proposed powers differ to what was in place prior to the new COVID legislation that was introduced in March or April 2020? Why is it necessary to have these extra powers when we were able to undertake certain measures and actions pre-COVID legislation in 2020?

Dr Gerrard: In terms of the three measures, we had no capacity to enforce isolation and quarantine requirements. At the moment it is a national position that five days isolation for patients with COVID-19 should be mandated. I do believe that that will end sometime in the coming months as we proceed to living with COVID-19. As of 31 October, it is likely that that national position from National Cabinet and the AHPPC may still be in place, so we still need the capacity to do that, although it is likely we will withdraw it sometime in the next 12 months. We did not have that capacity before March.

Mr MOLHOEK: Reflecting back to the first three months of 2020, many offices were shut and people were being told to work from home. There were a lot of actions undertaken prior to the introduction of specific COVID legislation. Are there other powers that the Chief Health Officer has or Queensland Health has that have historically been in place that would adequately deal with these measures?

Dr Gerrard: I think we still need these three measures. Historically of course we have been dealing with infectious diseases for years. We have a well thought out and established process for dealing with infectious diseases outbreaks in aged-care facilities, for example. On the specific issue of mandating isolation, the specific issue of mandating masks—even though we are withdrawing most of those mandates with the exception of healthcare workers at the moment—and the potential ability to mandate vaccination, we did not have that capacity prior to March.

Mr MOLHOEK: The explanatory notes talk about certain threshold conditions needing to be met. What would those threshold conditions be?

Dr Gerrard: Again, that will be determined by a number of factors. There is no single measure that I would use. It would be things like infection rates, hospitalisation rates and impact on healthcare staff. I do want to make it very clear—and I assume you have picked up on this: it is our intention to pull back. These measures are there really just in case. it is the current plan to be pulling back on most of these measures and in the coming months to have no or very limited legal mandates in place. They are really mostly in place as a just in case, particularly for us to be able to respond if there is a national decision that all aged-care workers could receive some brand-new very effective vaccine, for example—I am making that up. As we go forward, it is not our intention to use these measures unnecessarily at all. They are there particularly so we can respond in a coordinated manner with the other states as well. That is quite critical. If National Cabinet and the AHPPC make a decision, we need some mechanism to respond.

Dr ROWAN: I also acknowledge the complex, challenging and difficult circumstances that everyone has faced over the last couple of years and thank everyone for their hard work. The first question I want to ask Dr Gerrard is in relation to the new proposed regulatory framework. When you are matching that framework against the data collection that you will have moving forward—as you said, the epidemiological data, the expert advice, the number of intensive care beds, beds occupied, staffing issues, all of that data there. In the proposed legislation, is there enough flexibility within that to respond to that data? It is really the practical implementation in other words. There often needs to be a level of flexibility and responsiveness that is operationally implemented as opposed to what is contained just within the legislation.

Dr Gerrard: I think there is enough flexibility. I believe so, particularly for those three measures. If we needed to go beyond those three measures, which is very unlikely, then other processes would have to be implemented. That is very unlikely. I believe this legislation gives adequate flexibility for the situation that we are in now to implement these measures which are the ones we have identified might be required in the coming months. Again, I must emphasise that they may not be.

Dr ROWAN: Dr Gerrard, could the new proposed regulatory enabling framework be used to manage any other emerging controlled notifiable conditions or infectious diseases or is it just able to be used for COVID-19?

Dr Gerrard: It is designed specifically to deal with COVID-19. It is quite specific.

Ms PEASE: I would also like to echo the words of my colleagues and thank everyone for their great work. We often acknowledge the great work of our frontline workers, but I know the huge amount of work that goes on behind the scenes each and every day—for example, with this piece of legislation but also with the rostering and the admin. All of that is happening in the background. I would really like to acknowledge all of the hard work that goes on behind the scenes. Thank you very much.

I want to talk a bit more about what the member for Moggill was saying. We have heard about the three areas, but with regard to those areas that will not be able to participate—you talked about lockdowns and gatherings, for example—can you elaborate on that and provide further information about what sorts of things it cannot do?

Dr Gerrard: Those are the big measures we have had over the last two years such as lockdowns, the closure of schools and suchlike. There would have to be a very significant change in the virus and its epidemiology for us to consider implementing measures like that again. I am not going to say it is inconceivable, but I do not believe we should be building legislation around something that is very theoretical at this point in time. If there was some unexpected major change or shift in the virus such that it became much more contagious and/or much deadlier, which is unlikely, then that would need parliament's involvement, and I think that is appropriate.

Ms Joldić: There is a list of the matters that cannot be subject to the public health directions we have all experienced over the last almost three years: the directions cannot enable Queensland's borders to close to other jurisdictions; we cannot quarantine international or domestic arrivals; we cannot restrict the movement and gathering of people with lockdowns and the restrictions that have been in place before; we cannot require vaccinations for the general public, for example, when entering hospitality venues, and we have seen that before; and we cannot restrict access to vulnerable facilities unless necessary to support the effectiveness of the direction about isolation and quarantine. We have experienced that over the last 2½ years, but this bill is really a step-down approach.

As the member mentioned, we have really tried to strike a balance between the human rights issues we have experienced over the last 2½ years and what we predict will be necessary over the next 12 months. It is a step-down approach, and I would just remind the committee that the bill proposes a sunset clause of October 2023 as well. We are looking at this. We will continue to review what is necessary and of course provide advice.

Ms PEASE: Further to that, were we in line with other jurisdictions?

Ms Joldić: Other jurisdictions have very different legislative frameworks, but we have tried very hard to be in step with other jurisdictions. You would have seen that, for example, Victoria has introduced permanent legislation. We have really tried to balance our experience and the uniqueness of how we have responded in Queensland to make sure that this is the right balance of what we will require over the next 12 months. As Dr Gerrard mentioned earlier, it really is a last resort. We will be looking at reviewing the decisions as we go forward.

Mr SMITH: Thank you all for being here. I reiterate my thanks to all of those who played a role during the COVID-19 pandemic. It was a unique experience for us in regional Queensland. Over the last Christmas holidays especially we felt the impacts of COVID-19 in Bundaberg. I just have a few quick technical clarifications. Dr Gerrard, if a public health direction was given by yourself, the bill requires a justification statement within five days and then for that direction to be tabled in parliament within 21 days. Is the difference of five and 21 days more just to align with the parliamentary calendar, or is it more specific?

Mr Mahler: I am happy to answer that. The 21-day time frame to tabling of directions is really just recognising that the tabling process is a more formal process. It involves multiple layers of approvals and it can take some time as compared to publishing a direction on the Queensland Health website. It is still significantly shorter than the tabling time frame for typical subordinate legislation, which is 14 sitting days, so it still an expedited time frame so that parliament can quickly engage with

the public health direction. I suppose the other point I would make is that while the direction will have to be tabled within 21 days, the five-day publication requirement means as a practical matter that the direction and justification statements will be made public very quickly, and nothing would preclude parliament from beginning to consider those materials before they are formally tabled in parliament.

Mr SMITH: Could I get some more elaboration around the changing of the thresholds and how they are stricter and perhaps more disciplined compared to currently? If I could get some further elaboration around those thresholds, please.

Dr Gerrard: Are these the thresholds for requiring a mask mandate, for example? Is that what you are talking about?

Mr SMITH: Yes. When considering whether to make a public health direction around the new test that is spoken about, what are the new thresholds around what you would consider necessary?

Dr Gerrard: I think the first thing to say is that obviously history speaks for itself. It is our intention to revoke most of these mandates. If we are just talking about mask mandates, we have very limited mask mandates—just in the healthcare setting—at the moment. We had no general indoor mask mandate during the last wave, so it would clearly have to be a wave that was significantly worse than the last wave for us to require a mask mandate. What I can tell you, for example, is that since the last wave, which peaked 25 July, the majority of Queenslanders have now been infected with COVID-19 at least once and 93 per cent of Queenslanders have had at least two doses of vaccine, which means that the majority of Queenslanders now have hybrid immunity to COVID-19. The current international belief is that this is what is protecting the community and the public from severe waves of COVID-19.

We do not know for certain what is going to happen going forward. What we do know is that at the moment we have very high levels of immunity in the community and at this stage no obvious variant emerging. That could change in another week or two; we do not know. We do know that immunity will wane over time and it is likely we could get further waves, but at this stage there is nothing on the horizon to suggest we will get a worse wave than the one we just had. It is possible. Just going back to your original question, it is quite difficult to think of a circumstance under which we would implement another mask mandate. It is possible, but it is unlikely. It is possible, but we want to have it just in case.

In terms of changing isolation or increasing isolation, it is hard to see how we would change that. It is more likely that we would reduce it. In relation to the vaccination requirement, it is conceivable that would be used if some new vaccine was developed and it might be something that would be valuable in health or aged care. It is conceivable.

Ms Joldić: I would like to address the threshold issue and the nuance in the language and how it has changed. Currently, the Chief Health Officer can issue a direction if it is reasonably necessarily to assist in containing or to respond to the spread of COVID-19 in the community. Under the proposed bill the Chief Health Officer can issue a direction if it is reasonably necessary to prevent or respond to a serious risk to the public health system or the community as a result of COVID-19 and to give effect to advice from national bodies. There is a shift in the language and the threshold assessment.

With your permission, Chair, I would like to go through the safeguards again because, as I mentioned, we have tried really hard to strike the right balance and ensure that all of the safeguards necessary are in place, particularly talking to our key stakeholders. The powers will be subject to parliamentary oversight and other safeguards as mentioned. The directions must be reasonably necessary to implement national advice to respond to serious risk. Directions will expire after 90 days if they are still required and a new direction must be issued, so the directions will be reviewed constantly by the Chief Health Officer. The directions must be tabled in parliament within 21 days and are subject to disallowance in parliament, and the CHO must publish the rationale and human rights justification for each direction in order for it to be enforced by public health units. I think we have tried hard to put safeguards around it and raised the threshold issue as well.

CHAIR: I have the member for Mirani waiting patiently for a question. Over to you, member.

Mr ANDREW: I also would like to thank all of the health workers and frontline workers and also make sure we also remember the people who lost their jobs during this the pandemic with the mandates. Dr Gerrard, there is no type of formula that will be used to work out how we can move around the pandemic. When we went to QIMR we looked at a program called Covasim. What percentage of Covasim do you use in your decision-making processes?

Dr Gerrard: I am afraid I am not familiar with that; I am very sorry. Is that a program? I am sorry, I am not familiar with it.

Mr ANDREW: Yes, Covasim was shown to us at QIMR. It was a program that was delivered by Bill and Melinda Gates and the Burnet Institute. It was actually modelling all the different stuff right around the world. I noticed that the Premier said the modelling was not really correct. Was the modelling taken from that Covasim modelling or do we have our own modelling?

Dr Gerrard: If I can talk about modelling, what we have decided to do with our modelling is to work in collaboration principally with the University of Melbourne, which is the group that the Commonwealth use, so we have a more unified modelling process nationally. Our epidemiologists work directly with University of Melbourne epidemiologists to try and predict where this virus is going.

Having said that, the epidemiologists are having a great deal of difficulty now predicting with any certainty what is going to happen with this pandemic more than a few weeks in advance. That is why you are not really hearing anyone confidently coming out and stating one way or another whether, for example, we are going to have a wave in November and December. You may have heard—in fact, I spoke about it—that modelling we did through the University of Melbourne suggested there was going to be a significant wave in November and December. Now there is uncertainty about that because the numbers are very small at the moment—smaller than we expected—and no new variant has appeared. In terms of the modelling we use, we work with the University of Melbourne. At this stage there is not a clear prediction of what the next wave will look like. So far the news has been good, obviously.

Mr MOLHOEK: I was wondering if Mr Humphreys could just elaborate a little bit on some of the measures you have had to undertake within Corrective Services and some of the practicalities and challenges that you face in dealing with prison populations in such confined environments. I think it would be interesting to learn a little bit about that in this public forum as well.

Mr Humphreys: As my Queensland Health colleagues said earlier and you just alluded to, prisons are uniquely vulnerable to the spread of COVID-19 due to the close proximity of prisoners and staff and the very limited ability for us to maintain social distancing in prison environments. Despite those challenges, particularly with the Omicron variant, the measures adopted by Queensland Corrective Services, supported by these temporary amendments, have been successful in mitigating the risks associated with the virus to date. However, as the Chief Health Officer has said, it does continue to present risks for us that require management beyond 31 October 2022.

Our current response planning tool has three levels: baseline, standard and elevated pandemic responses. All correctional centres are currently at the baseline level. In the most recent wave in June and July the centres moved to the standard level but did not move beyond that level to the elevated level.

As Dr Gerrard has said, we do not expect to have to go to that elevated level in the future, and we certainly hope that we do not have to. We acknowledge that in an extreme situation, we do have to limit access to prisons by visitors. We have to limit face-to-face family contact and other things that we would view as essential to particularly rehabilitating prisoners and maintaining humane treatment. In the most recent wave, we did not go to the elevated level. We do not expect to need to in the future unless the virus changes in a way that is not currently anticipated. As I said, all centres are currently at the baseline level and we hope that that continues.

Mr MOLHOEK: I am curious to know the difference between the baseline level and the other level that you mentioned which eludes me. What does that look like in terms of measures within the prison? Is it people having to social distance in lines for meals, or what are some of the more practical aspects of that? I am just trying to get a picture of it.

Mr Humphreys: Our most recent declaration under this power was made on 22 September 2022, and that is for the period to 31 October 2022. These directions are informed obviously on advice from Queensland Health. The current directions include: staff members who are diagnosed persons or a close contact must not attend their workplace and comply with their supervisor's directions and Queensland Health requirements; any non-staff member identified as a close contact must provide evidence that they have complied with Queensland Health directions; all staff members and visitors to a corrective services facility must comply with mask-wearing requirements at that location if those requirements are in place; and all prisoners must wear a surgical face mask in certain circumstances, so when outside of their secure unit or residential compound, unless engaged in strenuous physical exercise, when outside their cell if the prisoner is a diagnosed person, and when outside their cell if the prisoner has been isolated or quarantined for COVID-19 on Queensland Health advice.

As I said, all correctional centres are currently operating at the baseline level pandemic response which includes physical distancing where possible—as I said, that is difficult within a correctional centre—compliance with Chief Health Officer directions and COVID-safe plans, use of

personal protective equipment in line with the QCS Commissioner's directions, and management of prisoners who are symptomatic, diagnosed or close contacts in line with Queensland Health advice and guidance, including isolation as directed.

Currently, our prisons are operating close to normal operations with some exceptions, one of which, which is provided for under this temporary modification, is temperature screening of visitors. Apart from that, I am pleased to say that our centres are operating fairly normally.

CHAIR: We are out of time. Thank you, Mr Humphreys, our Chief Health Officer, Jasmina and all the staff. I understand you will be back this afternoon to respond to any questions that might be raised as the hearing continues today. This concludes this part of the program. Thank you very much.

The committee adjourned at 10.18 am.