HEALTH AND ENVIRONMENT COMMITTEE

Members present:
Mr AD Harper MP—Chair
Mr R Molhoek MP
Mr SSJ Andrew MP (virtual)
Ms JE Pease 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 2.01 pm.

GERRARD, Dr John, Chief Health Officer, Queensland Health

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

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 welcome back the department officials. The final briefing today from Queensland Health is to address any questions from the committee which have arisen from the evidence heard at today's public hearing. I welcome you to respond to anything you would like to start with and then we will move to questions.

Ms Joldić: I would like to once more take the opportunity to thank those individuals and organisations who have made submissions to the committee's inquiry or appeared today to share their perspectives on the bill. As I mentioned in my remarks this morning, Queensland Health consulted with a range of stakeholders during the development of the bill. The view of these stakeholders were carefully considered and helped shape the final form of the bill. For example, during consultations, stakeholders such as the Queensland Law Society and the Queensland Human Rights Commission recommended further oversight and scrutiny should be achieved by requiring directions to be referred to a parliamentary committee for review. As a result of this feedback, the bill includes this requirement. I have heard what stakeholders have said here today and I appreciate the range of views offered on this important legislation.

Queensland is still adapting to self-manage the risks for COVID-19. There is no rule book to tell us how to adjust to living with a rapidly evolving virus like COVID-19. While there is a broad recognition that we are in a new stage of the pandemic, there is still a lot we do not know about COVID-19. We need to proceed carefully, we need to continue to listen to the health advice and we need to balance individuals' rights to self-manage the risk of COVID-19 with protecting public health. The bill is designed to achieve that balance. It is an enabling framework that allows measures to be scaled up when risks are serious and scaled down when risks are low. While the proposed powers are a significant step down from the current emergency framework, it is acknowledged they are still substantial powers. Measures like isolation can have a significant impact on individuals and their human rights. This is why the bill inserts a range of safeguards to minimise the impact on individuals and businesses to the greatest extent possible, while still meeting government's ultimate responsibility to protect the health and safety of its citizens.

I would now like to take this opportunity to respond to some specific issues raised by the stakeholders today. I now turn to the matter of how the test for issuing a direction is proposed to work. The Queensland Law Society suggested that the legislation could prescribe the factors that may be considered in determining whether there is a serious risk. The legislation purposely does not list specific factors that must be taken into account. COVID-19 has been unpredictable. As Dr Gerrard explained this morning, there is no simple formula. It requires a case-by-case assessment of a range of complicated clinical, behavioural and epidemiological factors. It requires the Chief Health Officer, as an experienced medical officer, to carefully weigh up all of the relevant information.

It is important that we retain flexibility in the legislation to consider all relevant matters in deciding whether serious risk exists. The Chief Health Officer will be required to provide a justification statement for every direction. This statement will provide detail about the factors considered in determining whether serious risk has been met. Parliament also has an important role to play in reviewing the rationale and justification for public health directions. This includes examining whether the public health measures are appropriate and proportionate to the risks they are intended to address. That said, serious risk is a high threshold, significantly higher than the current legislative

threshold for issuing directions. Combined with other limitations and safeguards in the bill, this threshold places meaningful constraints on when and for what purposes public health directions can be given and for how long directions can remain in place.

Stakeholders have also noted that the bill does not include review rights. Public health directions set out who the direction applies to and who is exempted from the direction. For example, directions about mask wearing include exemptions for children under a certain age. The direction on isolation enables a person to leave to seek medical treatment at a hospital or to avoid injury or illness, as an example. In addition, the Chief Health Officer has had, and will continue to have, the power to exempt individuals from complying with a direction on a case-by-case basis. While it is ultimately a matter for government, the Chief Health Officer has demonstrated throughout the pandemic that we can build flexibility into our direction regime by providing rights of exemption on request. In this context, while the review mechanism is not included, the bill does allow the Chief Health Officer to make directions that can be applied flexibly and quickly adapted when required to suit local circumstances. This approach has served Queensland well during the pandemic. Formal rights of review would likely prove difficult to administer, particularly in regional Queensland, and may undermine confidence in the directions.

The Queensland Human Rights Commissioner also queried why temporary laws are most appropriate rather than fit-for-purpose permanent legislation. A range of options were carefully considered in developing the bill, including permanent pandemic laws or permanent COVID legislation. This ultimately is a question for government. However, I would like to say that the risks, severity and impacts of COVID-19 over the long term remain uncertain. This suggests it may be premature to implement permanent laws to respond to COVID-19 at this time. Enacting temporary provisions for 12 months ensures government is only legislating for the measures likely to be needed in the future. It also allows a more targeted approach with a limited range of powers that are narrowly defined. We are happy to take any questions.

CHAIR: Thank you very much. I was very interested in the five points the Pharmacy Guild raised in their submission. I must take you back to the former term of government when the health committee then produced a bill—I cannot remember the title of it—around expanding the scope of practice of pharmacies and a number of other things. I think if we had not done that, we would not have been able to see what the community pharmacists were able to do during the pandemic, including giving vaccines to young people. They did raise the fact—I do not know if you can talk to it at all—that there was separate consultation with Queensland Health around their concerns. I will allow some latitude in the response.

Ms Joldić: Thank you for that, Chair. I am across it and we are certainly talking to the Pharmacy Guild. It is a separate policy matter, but I will attempt to respond to the issues they have raised today and I am very happy to supplement further if needed.

Section 58 of the Medicines and Poisons Act 2019 allows the director-general to make an emergency order to be made on a range of bases. The director-general has made three emergency orders on that basis that there is a declared public health emergency in place. These directions relate to COVID-19 vaccinations, schedule 4 medicines and the national medical stockpile. Section 58 of the Medicines and Poisons Act also enables an emergency order to be made if another event at state or local level poses a health risk, including an event that has the potential to cause human disease through exposure to infection. This would enable the director-general to make new emergency orders under the Medicines and Poisons Act, not this bill, even if a declared public health emergency ends on 31 October this year.

Whether or not these measures should be made permanent is a separate policy issue, as mentioned earlier, and they are issues that relate to the Medicines and Poisons Act. This bill only deals with the COVID-19 response. Any permanent changes would need to be subject to a separate consultation process with stakeholders, including the Pharmacy Guild. This is a complex area and it has implications for the PBS as it interacts with the national Poisons Standard. We certainly are talking, as we normally do with our stakeholders, but it is a separate discussion and separate engagement process.

CHAIR: Thank you very much for your response on that.

Mr MOLHOEK: My first question is with respect to the justification statement. The Queensland Law Society raised some concerns around the definition of 'serious risk' and a few other matters. In regard to the justification statement, would it be the intent of Queensland Health to provide a fulsome background on the health advice that is received and openly disclose as much of that data as possible?

Ms Joldić: You will see that what we are proposing in the bill is that we will publish the rationale for the decisions that are being made. That is why we are saying that we are doing this on a case-by-case basis and allowing the Chief Health Officer to have the flexibility in what he or she—in this instance, he—would take into consideration for making those decisions and making those directions. It is our intention that the proposed bill stipulates that we would publish the rationale for making those decisions.

Mr MOLHOEK: One of the criticisms during the more active phases of the pandemic was that there were frequent calls not just from the opposition but from many parties saying, 'We want to see the health advice.' There were daily media conferences saying, 'The health advice is we have to do this and we have to do that,' and many people were saying, 'Well, we want to see the health advice.' What sort of information would we expect to see in that health advice?

Ms Joldić: I will ask Dr Gerrard to respond as to what he will take into consideration and how we will document that.

Mr MOLHOEK: That is exactly what I wanted to hear, thank you.

Dr Gerrard: We would take into consideration the level of transmission in the community, the number of cases in hospital and in intensive care units, whether we had a new variant of the virus which was more transmissible or more deadly. There have been various attempts in various jurisdictions, both here and overseas, that define thresholds for when you would change your measures, and every time it has not worked terribly well because prescribing those numbers in advance is very difficult.

When you actually get to the situation where we have all of that information in front of us, I think that decision should become pretty obvious. If there is a serious problem, we will see people being admitted to hospital at a rate which is, for example, significantly higher than what we have just seen in this third wave. We saw that in this third wave we didn't implement major restrictions. However, it should be obvious, based on hospitalisation numbers, staff absenteeism et cetera that we have a significant problem. Again, I must emphasise that my feeling is that this almost certainly will not be necessary, but it is there in case we need it. I do not want to promise we will not use it, because that is why we are all here, but at this stage it is somewhat theoretical. However, we need to have these measures in place should they be required and particularly so we can align with other states of Australia.

Ms Joldić: I am very happy to have a conversation, so please tell me if you do not want me to respond. As public servants we are very much geared into doing pro forma and administering advice in terms of how we brief and how we capture that advice. While we want to retain a level of flexibility, it is an administrative function that we would look at standardising as much as possible to capture all of the thinking and all of the advice and evidence that we have to ensure that the purpose of this is that we are transparent in what we are taking into consideration when making decisions and obviously publishing that. While we do want to try to standardise, we also want to retain a level of flexibility to allow us to take as much information as possible into consideration.

Mr MOLHOEK: Sure. The other issue that we have heard a little bit of discussion on today is around the cascading of powers. I am not asking you for an opinion so much but more if the legislation were to change that cascading of powers so that the initial declaration was made by an elected member and then it flowed to the Chief Health Officer or vice versa, can you see any significant disadvantages or advantages in it being either/or?

Dr Gerrard: I am not sure that I understand the concept, sorry. You will have to explain that a bit to us.

Mr MOLHOEK: The issue that has been raised by the Human Rights Commission, the Law Society and the Council for Civil Liberties is that at the beginning of any process of declarations or decisions of government or actions by government the initial declaration should be by the minister or the Premier. There should not be a power that allows the health department or a bureaucrat to make the initial call but rather the elected members who are accountable to the public. My question is: if it was not the Chief Health Officer's first call but it was the minister's first call and then it flows through, do you see any substantive issues or risks in that being reversed like they have done in Victoria?

Mr SMITH: I raise a point of order, Chair. Is that asking a member of the department or an official to make an opinion on government policy and government legislation?

Mr MOLHOEK: Chair, I did couch that. I am not asking for an opinion; I am just asking whether it would change the effectiveness. By switching those two roles around, do you see any major problems with that?

Dr Gerrard: This is, say, if we decided to mandate masks for everybody for indoor use because there was such a terrible wave of pandemic that the Minister for Health would make the declaration rather than me in parliament? It is government policy. It is not immediately obvious to me why there would be a problem, but my colleagues on the left may have identified a problem with that.

Mr Harmer: Just responding in terms of legislative design, I would probably make the observation that one of the features of this bill is that the direction, once made, must be published and it is then subject to disallowance, so the parliamentary scrutiny that is being sought is already provided for in the legislation in some respects. I think changing the nature of the decision-maker would probably take away from the ability to have someone who has an intimate understanding of the health factors in forming the decision to decide quickly and effectively.

One of the features of Queensland's response has been that our chief health officers have been able to decide based on the health information available to them and act immediately with authority and the decisions have been generally well accepted by the Queensland community. So while it is an opinion on my part, I think there is no particular advantage in changing the framework and parliament would have the opportunity to scrutinise and potentially disallow a direction under the framework that is proposed.

Mr MOLHOEK: I am playing devil's advocate on the question. I am not sure how I feel about it, but it has been raised that you are essentially giving power to a senior bureaucrat rather than an elected official who has a level of accountability back to the electorate that does not necessarily sit with, say, the Chief Health Officer or other person.

CHAIR: I think they have answered the question. We will come back if you have a supplementary, Deputy Chair. Member for Mirani, do you have a question?

Mr ANDREW: Yes, I do have a question. Given everything that is going on with the mandates, at the beginning of this year did Queensland Health see an increase in sick leave and compensation leave within the ranks of the health service?

Dr Gerrard: An increase in sick leave in the health service?

Mr ANDREW: Yes.

Dr Gerrard: Yes, very substantially.

Mr ANDREW: That is correct. Did you notice it within the hot HHSs and the frontline workers?

Dr Gerrard: The very substantial amount of sick leave among frontline healthcare workers at the beginning of the year, yes.

Mr ANDREW: Yes. If that was the case and we had a high vaccination rate, did the mandate for vaccinations really work?

Dr Gerrard: The vaccine protects against severe disease, so it does not necessarily protect against mild infection. In the healthcare environment, even if a healthcare worker had a very mild infection like a head cold, they were required to isolate in order to protect patients. That was an order to protect the patients from an infection from an infected staff worker. They were vaccinated and to my knowledge—I am pretty sure about this—I do not believe that we have had any deaths from COVID among staff in Queensland Health. I am pretty sure that is correct.

Mr ANDREW: Yes. I have another quick question about the serology and also having antibodies from having COVID, even in unvaccinated people. Will we ever get to a stage where that will be considered as a way of being able to enter back into the health system? Have we done tests between boosted people and people who have actually acquired COVID without being vaccinated? Shouldn't we be looking at people who have immunity already—just natural immunity? Is natural immunity not good enough? Are we saying now that vaccines are the only way forward for the people of Queensland? I cannot get over this given that we are not actually taking that into consideration.

Dr Gerrard: No, that is a legitimate question and we have looked at this. There are a couple of issues with it. The antibody tests are still somewhat experimental and there are false positive results, so you can have antibodies and not have actually had infection or a positive antibody test and not actually have had infection. Secondly, we know that whether or not—I am going to go slowly with this because it is a bit mind twisting—you have or have not been infected, being vaccinated as well is always better in terms of your immunity. If you have been vaccinated and have had infection, your immunity is superior to having just had infection; or if you have been vaccinated and have not had infection, then obviously your immunity is superior if you have been vaccinated. Did you get that? That was a bit mind twisting. The bottom line is that, whether or not you have been infected, being vaccinated always gives you superior immunity. That is the rationale for mandating vaccinations in healthcare workers.

CHAIR: Are you happy with that, member? If so, we will move to a question from the member for Bundaberg.

Mr SMITH: Dr Gerrard, a question coming from the Queensland Law Society was around them wanting to seek some form of a definition or explanation around serious risk when making a public health direction. I will not ask your opinion obviously on a criterion and so forth, but I wonder how much the general public's knowledge and understanding of how to deal with COVID-19 and the spread of a new variant comes into play. I suppose maybe the example would be around the latest wave not putting in a mask mandate because there was quite an understanding from the public that, 'If I do get COVID and if I test positive, I know to isolate at home and go into quarantine. I can wear a mask if I feel free.' How much does the general public's knowledge and understanding of COVID now weigh up in your decision-making around a public health directive?

Dr Gerrard: What I would say is that it is currently our intention to have a system whereby we alert the public to the level of transmission in the community. We have not published this yet, but we are preparing it at the moment—that is, to alert the public if we are going into a wave with the data to show that and giving specific recommendations and advice to the public about what measures they should take to protect themselves, but that would not in and of itself preclude the need for these measures if something much worse happened. So we still need these in place should something much worse happen, but we do need a means of communicating clearly with the public if and when we enter a wave so that they can modify their behaviour, voluntarily for the most part. For example, if we are in a wave like we have just had, we would enter a red system on our traffic light alert system recommending that everyone wears masks indoors but not necessarily mandating it unless there were very specific circumstances such as if it were a serious threat to public health.

Ms PEASE: I am not sure if you said that you were listening to the earlier stakeholders who came and gave us information. I am particularly interested in the matter for Corrective Services, and I note that the commissioner is not here at the moment. There was a lot of discussion as to why the period of 90 days has been applied for people in a Corrective Services setting and whether there has been any consideration given to reducing that.

Ms Joldić: I might ask my colleague Karson if he has a view, but I think we would have to take the question on notice given it relates to the Corrective Services Act.

Mr Mahler: What I can do is provide some material that Corrective Services have provided to us and then we will probably take the question on notice to provide any further information. As noted, the temporary powers under the provisions of the Corrective Services Act last up to 90 days for a declared emergency. The bill extends the scope of the Corrective Services Act emergency powers as currently modified with one change. The change is to replace the limitation on the use of the powers while COVID-19 is a declared public health emergency to limit its use to where COVID-19 is a controlled notifiable condition. These provisions have only been used to declare an emergency in response to COVID-19 and not to any other emergencies, so there are some constraints around the use of those emergency powers.

The Corrective Services amendments are limited to the context of corrections and they are not as broad as the public health measures which can be applied to all of Queensland under the public health direction powers in the Public Health Act. Corrective Services has a responsibility to manage the people in its care and to ensure the health and safety of prisoners and staff. There are a number of additional operational legislative safeguards in place to ensure that only measures that are necessary will continue to be used. I will not go into the detail of those. I think it is probably more appropriate that we take them on notice.

Ms PEASE: It would be good to have an understanding of that because it was a significant issue, particularly for Prisoners' Legal Service. The other area that they raised concerns about was access to legal and medical appointments during a period of lockdown and also access to other services. For example, as part of their rehabilitation for parole they have to have undertaken work practices et cetera and they are not able to participate in that if there is a lockdown, and therefore that is going to impact on their capacity to get work once they are out of prison and go on to parole. I would really like to find out about that in terms of how they arrived at another 90-day lockdown period and the impacts on having access to all of those range of services and the justification for it.

Mr Mahler: Yes, absolutely. We are happy to seek that additional information.

Ms Joldić: Yes. We are very happy to take that on notice and provide that information.

Ms PEASE: Thank you.

CHAIR: We have a supplementary question from the member for Mirani.

Mr ANDREW: In regard to the answer to the earlier question that vaccines give us the best immunity, I am struggling with how many we need. What are we up to now—four or five? How many do we need to get superior immunity? There are people out there who have never been vaccinated who have had COVID once and have never had it again. There are others out there who have been vaccinated four times and who have had COVID two, three or four times.

Dr Gerrard: Your question is very legitimate. The vaccine strategy going forward is as yet unclear. It is likely at this stage that we are going to be recommending—and I am trying to peer into a crystal ball here—an annual vaccination with COVID-19 vaccines, particularly for the vulnerable. That seems to be the way we are going forward with this. Do remember that we are talking about mandating vaccines through this process. There is no specific intention to do that going forward. This is really to have that process in place.

The example I gave before was that, if there were a vaccine that was vastly superior to the current vaccines, we might mandate for health aged-care workers going forward. That is the sort of circumstance under which we might use this mandate. I think there is a good chance we will not ever use this mandate. I really must emphasise that. It is just to have it in place. For example, if AHPPC, National Cabinet or ATAGI came out and said, 'You have to have this fantastic new vaccine X. All aged-care workers really need it because it is completely protective,' we need the capacity to do that. That is the sort of circumstance where I can see us potentially using this mandate.

I suspect—and, again, I am peering into my crystal ball—we probably will not use it. Most of the mandates now are under an occupational health and safety framework. Healthcare workers in hospitals, for example, at the moment are required to be vaccinated to protect themselves as directed by either the Department of Health if it is a public hospital or by the private health providers. It is there principally to protect themselves as an occupational health and safety measure. We no longer have Chief Health Officer public health mandates for healthcare workers in hospital.

At the moment the only existing mandates for vaccination under a Chief Health Officer direction are—there are two—for workers in aged care and for workers in disability services. The reason these two specific mandates exist is (a) because of the high risk of patients involved but, more specifically, because this is a recommendation from the national AHPPC group. There is a chance that this will not continue depending on what the national decision is. I answered that in a rather roundabout way.

The other possibility is that we have a much more virulent virus out there—much more contagious—and the current vaccines have no value whatsoever but a new vaccine does. We might want to mandate healthcare workers to receive that vaccine. That is the sort of circumstance where I guess I can imagine us using it. It does require a little bit of imagination to think of the circumstance where we would use this.

CHAIR: It is hard to look down the road. Some could say that, outside of health workers, in a year's time we will be encouraging the broader public in terms of the uptake of the annual influenza vaccine.

Dr Gerrard: It is hard to see how you would use this for the broader public now—maybe specific occupational groups such as in prisons. The idea is to have it there for the next 12 months, because we are not totally certain what is going to happen with this pandemic in the next 12 months. Let's hope that after this 12 months this will be a virus similar to seasonal influenza. It might not be, but that is what we are hoping.

Mr MOLHOEK: We will probably have an app by the time we get to another pandemic.

Ms PEASE: We have done that!

Mr MOLHOEK: You will push the button and just put a force field over yourself and keep the aliens away while you are at it!

I want to ask some questions around the submission from the Queensland Nurses and Midwives' Union. They raised a suggestion that there needs to be workforce planning around surges—almost like a reservist approach, I suppose, to certain specialities within nursing. Has consideration been given to that? What is the view of Queensland Health on their suggestion that we need to be making other provisions around these sorts of surges in demand?

Ms Joldić: It is a really good question, to be honest. Yesterday we had our Queensland Health workforce summit. QNMU were obviously invited, as were a broad range of stakeholders. There is no doubt, as raised in our statements earlier this morning, that our staff have done an incredible job, but they are tired and we have seen furloughed staff. We are going through our process internally of continuing to learn the lessons not just from the COVID pandemic but, generally, we have reviewed

processes internally where we learn lessons and plan for the future as much as we can. Yesterday the workforce summit was one of those days where we really zoomed into the workforce issues and the challenges we are facing, not just in Queensland but more broadly across Australia.

Internationally there are some mind-boggling statistics out there. There will be 14 million vacancies in the health space more globally. There are 300,000 vacancies in the US. With that in mind, we have an obligation to plan for the next 12 months, two years, five years or 10 years for where we need to be as part of our broader reform agenda. We are most certainly focusing on the workforce challenge that is in front of us and on what will also be there in the future. It is part of our planning process most certainly.

Mr MOLHOEK: Hopefully the worst is behind us, but we do not know the future. We do not have a crystal ball. Have there been any significant learnings or thoughts around how we could better maintain the ongoing operations of so many other areas of Queensland Health if this were to happen again? We have seen a lot of elective surgeries put off. We have seen a lot of outpatient services delayed. Has there been a debrief of sorts and thought given to how we can improve? I almost do not want to say that word because I think everyone has done an outstanding job, but there have been a lot of other issues along the way.

CHAIR: To keep it in context, Deputy Chair, we had a lot of Queensland Health staff giving vaccines at major centres as well. I will allow some latitude.

Ms Joldić: I will answer in global terms and what we administratively do. I think I mentioned this very briefly in my earlier response. As public servants, that is what we do. We provide the services and we continue to review ourselves and make sure that we do the best job we can any given day. It is incumbent on us to make sure that we learn the lessons, that we communicate, that we share those lessons and that we engage with our stakeholders in those lessons learned. I am sure in the COVID-19 space we have done a lot of debriefs at the executive level. We continue to have those conversations with our staff. We have had farewells for quite a number of staff internally and we have taken on board their feedback as well. More formally, there have been issues around making sure that these lessons are learnt in the COVID-19 space. I will ask Dr Gerrard to comment predominantly around the pandemic and how we have done the debriefs and the lessons learned.

Dr Gerrard: Indeed, we are debriefing across all the services that were involved in COVID-19. We have learnt some things that we did not do before that will probably change our practices going forward. The obvious one is virtual care. That was a concept that came out of necessity from COVID-19, but we found that that is a very efficient way of seeing patients who are outpatients. Surprisingly we thought that patients would not like it, but they actually love it because they are not sitting in hospital waiting rooms waiting for their appointments. We have learnt things that we will adopt in practice in health as a result of COVID-19.

Mr ANDREW: My question concerns the ongoing workings with National Cabinet. Now that the powers will be rolled back, will that continue? Shouldn't it fall back to the Legislative Assembly and the people representative of the state of Queensland rather than any other oversight or other powers being evoked by the National Cabinet and its meetings therein?

CHAIR: I do not know that you should be commenting on that. That is a matter for the Premier.

Ms PEASE: So you want to ditch COAG?

CHAIR: It is a matter for the Premier who represents us at National Cabinet. It is probably not a question for departmental representatives here today, member. Do you have another question?

Mr ANDREW: Yes. We talked earlier about the gold standard for vaccines. I thought the gold standard was stopping transmission. We have a vaccine in Australia developed by a gentleman at Flinders University that does stop transmission but we still have not trialled it. Why do we keep going down the track where we perpetuate transmission by not having a vaccine that stops it or limits it? We have one that has been developed in Australia which actually stops it. Can you give me any reason why we are not trialling this?

Dr Gerrard: I am familiar with the vaccine that you are talking about. It is certainly not our decision about performing vaccine trials or licensing them. That is a job for the TGA and ATAGI. That is not our role.

Mr MOLHOEK: In terms of the scope of the legislation and the declarations that you could make as the CHO, is there capacity or flexibility within that to regionalise those declarations? Could it just be South-East Queensland that has a mask mandate but the rest of the state does not under certain circumstances?

Dr Gerrard: Yes, I believe so.

CHAIR: I think that is what we saw during the pandemic.

Mr MOLHOEK: Yes, we did. I was just wondering if that was continuing.

CHAIR: There being no further questions, I have to thank you all for being here today. I also have to remark on the former chief health officer, Dr Jeannette Young, who certainly led the state in that first really difficult period. Dr Gerrard, you are doing a remarkable job. Thank you for continuing to look after Queenslanders. Again, I thank the departmental representatives. There are two questions on notice. If answers to those questions could come back to the secretariat by 10 am on Tuesday, 4 October that would be greatly appreciated. We have certainly appreciated your contributions and responses today to questions. Thank you to Hansard and the secretariat. I now declare this public hearing closed.

The committee adjourned at 2.42 pm.