HEALTH AND ENVIRONMENT COMMITTEE

Members present:
Mr AD Harper MP—Chair
Mr R Molhoek MP
Mr SSJ Andrew MP (virtual)
Mr ST O'Connor MP
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 HEARING—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 10.21 am.

CHAIR: Good morning. I declare open this public hearing of the committee's inquiry into the Public Health and Other Legislation (COVID-19 Management) Amendment Bill 2022. I am Aaron Harper, 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 now share. With me here today are Mr Rob Molhoek, member for Southport and deputy chair; Mr Stephen Andrew, member for Mirani who is on teleconference; Ms Joan Pease, member for Lytton; Mr Tom Smith, member for Bundaberg who is substituting for Ms Ali King, member for Pumicestone; and Dr Christian Rowan, member for Moggill. I understand there will be some movement of other members during this hearing. We will introduce them as they come.

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. 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 members of the public that they may be excluded from the hearing at the discretion of the committee. These proceedings are being recorded and broadcast live on the parliament's website. Media may be present and are subject to the committee's media rules and the chair's directions at all times. You may be filmed or photographed during the proceedings. Please turn off any mobile phones.

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

PRENTICE, Mr Daniel, Professional Research Officer, Queensland Nurses and Midwives' Union (QNMU)

CHAIR: We now welcome, from the Queensland Nurses and Midwives' Union, regular contributors to the Health and Environment Committee, Mr Daniel Prentice and Ms Kellie Dwyer. Thank you for your submission. Would you like to start with an opening statement before we move to questions?

Mr Prentice: Thank you very much. We have a brief opening statement. Good morning, committee members. I, too, acknowledge the traditional owners of the land upon which we met, the Yuggera and Turrbal people, and pay my respects to the elders past, present and emerging. The QNMU thanks the Health and Environment Committee for giving us the opportunity to present our views on the Public Health and Other Legislation (COVID-19 Management) Amendment Bill 2022.

The QNMU is the largest union for nurses and midwives in Queensland. We have over 67,000 members and we are here to represent their interests. We take the opportunity to recognise the critical role that nurses and midwives have played in working on the frontline during the COVID-19 pandemic. Their response to the pandemic has shone a light on how valuable they are to our healthcare system and community. We believe nurses and midwives have been pivotal in Queensland and Australia's success in dealing with the pandemic.

The QNMU recently made a submission to the Public Health and Other Legislation (COVID-19 Management) Amendment Bill 2022 where we expressed our broad support for the proposed legislative changes. Today we will limit our opening statement to comments to key areas of the bill.

The QNMU does have concerns that in restricting the powers of the Chief Health Officer in leading a public health response this may affect the CHO's ability in handling future pandemics or COVID-19 variants. The QNMU is supportive of a quick and timely response to future public health emergencies and is therefore cautious in restricting the CHO's remit. A quick response is essential to protect at-risk and vulnerable populations such as the elderly who have been impacted disproportionately from a mortality perspective.

The QNMU also raises concern with the stipulation that a public health direction is to be tabled within 21 days of the direction being made and can be subject to disallowance by parliament. The QNMU suggests that the mechanism for promoting transparency and scrutiny of directions must be proportionate and not impede the ability to rapidly respond to future outbreaks of COVID-19 or prepare for potential pandemics. For this reason, we raise that a caveat should be included in the bill in the form of a notation.

The bill proposes to extend the COVID-19 measures in the Corrective Services Act which we generally support. We do, however, ask that consideration be given to the practicalities if a declaration of emergency is made for up to 90 days in regard to workforce. For this to be effective, a surge workforce strategy for not only nurses but also all corrective services workers will be needed to ensure these COVID-19 measures are effective, adequate and safe.

Finally, we take the opportunity to support planning for the impacts of the post-COVID-19 condition. We are supportive of the bill in removing entitlement to compensation for losses or damage incurred in relation to a public health direction. However, we suggest that consideration will be needed for those individuals who are affected by the post-COVID-19 condition and whether they will be subsequently affected by economic stresses related to this condition and whether they may need financial assistance. Further, when looking at the post-COVID-19 condition, we would support the amendment of the legislative framework to allow for future national statistical analysis of the long-term impacts of COVID-19 disease on the population to target future research and public health responses. Most importantly, we, as a society, must learn from the COVID-19 pandemic and ensure that those lessons are imbedded at the system level to support future responses to pandemic threats. Thank you for the opportunity to speak to you today. That concludes our opening remarks.

CHAIR: Thank you very much, Mr Prentice. Before we start, it think it is appropriate to recognise each of those 67,000 members the QNMU represents, the hardworking nurses and midwives who had enormous pressures placed upon them in managing the COVID pandemic. We thank them for their dedication and professional work in looking after so many thousands of people affected.

Dr ROWAN: Thank you very much for your submission. In relation to your comments with respect to long COVID and post COVID, including within the schedule 1 notifiable conditions list in the Public Health Regulation 2018, can I ask specifically, given the complexity across various hospital and health services and individual clinical services and that information being collated, captured and coordinated with corporate office through the division of the Chief Health Officer, would you have any recommendations from the QNMU in relation to how that is done and any additional work that needs to be put into information technology systems or other things that you receive from members about how that information is captured, for clinical service planning into the future?

Mr Prentice: No. I would not hazard any sort of detail at the moment around how that might occur. You are right, collecting information is a complex issue. Our perspective was more from the point of view that all the indications are that long COVID is likely to be a significant and lasting chronic health issue, not only in Australia but also around the world, and that as part of preparing for that, we need to consider how we might both collect information on and identify those who are diagnosed as having that chronic condition so that we are better able to plan services and provide services to those who may be suffering from that.

At the moment we are still in a pandemic situation, and hopefully that now is the latter stages of that, and when the pandemic is finally declared over, those issues for a lot of people will remain at a personal level, at a financial level, at an economic level and a societal level, and they will comprise a large number of people.

Anecdotally, I had previously heard that I think there was a long COVID clinic established in the ACT and already the demand for those services has surpassed that clinic's capacity and they have established a waiting list, so I think that may well be a predictor of what is to come. We would certainly encourage any effort to both identify and support those people who have that condition. I am sorry that I cannot answer in any detail on that, but, as you indicate, that is a complex issue.

Mr MOLHOEK: In your submission, Mr Prentice, you talked about the need to consider surge workforce plans. I am just wondering if you could elaborate on that. Was that just in reference to the needs within corrective facilities or were you looking more broadly than that?

Mr Prentice: I think that is both in corrective services specifically because that has some unique characteristics—so I will respond to that one first—but I also think that more broadly the issue of surge workforce is a core issue in how we respond to future pandemic threats.

From the point of view of corrective services, it is a relatively unique situation. We have two services working together both from a health perspective and corrective services perspective and it is a highly abnormal situation in that you have a population of inmates serving custodial sentences. It is a specialised area of practice and, as with any area of specialised practice both in terms—I do not want to speak for custodial officers—of my view from them and from a nursing perspective, that is a specialised area of practice and you simply cannot find replacements for those people at short notice. So I think having some planning around how you might meet those requirements should the situation arise in the future is certainly something that has to be considered specifically for a corrective services perspective. Is there anything you wanted to add to that at the moment?

Ms Dwyer: No, but to Dan's point it is a highly specialised area of nursing focusing predominantly on primary health care and the rehabilitation of those patients or clients who are incarcerated or imprisoned, so I think it is recognising that with that type of work comes not only a clinical and professional need for speciality but there are certain clearances and checks that do make it very challenging to replace the workforce at short notice or during periods of lockdown or furloughing. So I think it is having a workforce plan that is very attune to the needs of corrective services and the work that nurses do in that area and then it will be also to think of the more broader workforce surge support.

Mr Prentice: Yes. Certainly from a broader workforce perspective, that becomes very critical when we saw the Omicron wave earlier this year and the large number of staff, for example, who were furloughed and therefore unable to work. My portfolio area is aged care and, again, as you might have seen, the need to develop a surge workforce in that space while not a state responsibility has certainly been an outcome of the pandemic as well. So I think across the board we need to consider that, should there be a future event similar to COVID or potentially worse, part of the way that we plan for the system to meet that emergency is the surge workforce and how we go about making sure that is essentially in reserve.

It is reasonable to say from a nursing perspective that a nurse is not a nurse is not a nurse; they are not interchangeable and slottable into myriad positions. Like all aspects of health these days, nursing and midwifery practice is specialised and simply moving people around—while it may be an absolute necessity—does not always easily meet the needs of that particular situation, so giving some thought to how we develop a surge workforce for future contingencies is, I think, very important.

Mr SMITH: I might quickly just continue along that line. With regard to the requirements or the different skills or different professional developments that nurses need to undertake to be able to work in the correctional facilities, I would ask you to elaborate a little bit on that. Is that specifically undertaken by nurses within the HHSs that have a jail in their location or is it open across the board in a more broad sense?

Mr Prentice: I am just trying to think where to start on that one. Certainly from a corrective services point of view, I think that would be a reasonable expectation for those hospital and health services that do have corrective services facilities in their domain. Yes, that would be the expectation that there is planning in place should those corrective services facilities be impacted by either a future COVID variant—and, again, this pandemic is not over but hopefully ending—and for any future events. Again, future events are difficult to plan for, but I think there is a lot we can do.

In terms of nursing specialisation, it is simply a factor of the way that the healthcare system is structured these days. Just as we have medical specialisation, you could almost even argue that general practitioners are a kind of specialisation these days. Nurses are very much the same as well, so I guess it gets back to what I said before—that is, that a nurse simply is not a nurse is not a nurse and that there is a whole range of issues that need to be considered, whether it be training and education or scope of practice. They are just two issues that need to be considered when we are developing the workforce that can meet those future issues that, as we saw with COVID, can develop quite quickly.

These days a virus can be spread around the world within 24 hours, so often times we will have to act quite quickly. Having some redundancy and capacity in our nursing and midwifery workforce to meet those needs is certainly something that I think deserves significant consideration given that they are the majority of the workforce in health and, as you have seen through the pandemic, have shouldered a large proportion of that direct patient care role that we have provided over the last three years.

Mr SMITH: I imagine that some of that specialised training falls in part in terms of the formulation to Queensland correctional services as well in linking with Queensland Health; would that be correct?

Mr Prentice: Again, I can only comment generally. The corrective services portfolio within the QNMU is not mine, but certainly as two departments that are jointly responsible for the care of a group of people who essentially cannot go anywhere our expectation would be that those two departments would cooperate at the greatest level to ensure that those operations run smoothly and that they are able to meet the needs of those serving custodial sentences in the event of a future event.

Mr SMITH: Just highlighting your submission, it states—

The QNMU also wishes to highlight that in stipulating that a public health direction is to be tabled within 21 days, this timeframe must not impede a quick response in public health measures being implemented.

Did either of you happen to hear the previous witnesses when I put the question around the five days for a justification statement and the 21 days and did that maybe help to answer the question?

Mr Prentice: No. I think we had just arrived just as the previous group were finishing.

Mr SMITH: When Hansard do their wonderful work, I would encourage you going back and reading that because it provides a much better answer than the one I could do.

CHAIR: Before we go to a question from the member for Lytton, welcome, member for Bonney. We might go to you after the member for Lytton.

Ms PEASE: Thanks very much for coming in. Again, I would like to thank all of your members for all of the great work that they have done during COVID keeping Queenslanders safe and their continued dedication during the busy times of Queensland Health at the moment, so thank you. I am interested in talking about the three areas that this bill will enable to be enacted, with one of them being vaccination. I know that broadly the nurses union was supportive of mandating vaccinations. Where do you stand with regard to that in terms of the future?

Ms Dwyer: With regard to ongoing—

Ms PEASE: The mandatory vaccination as in the terms of the bill?

Ms Dwyer: We can only really speak to that in our capacity as registrants under the NMBA in that we do support vaccination and the requirement for vaccination however so directed because it has a broader community health impact. The leaders of our union are also registrants, so we have to oblige our Code conduct obligations on that.

Ms PEASE: Just further to that, I would like to elaborate on that further in terms of the types of vaccinations. I understand that there are mandatory vaccinations for other conditions such as whooping cough.

Ms Dwyer: Yes.

Ms PEASE: Exactly. So they have always been in place?

Mr Prentice: Yes.

Ms Dwyer: Yes. Under the HEDs, yes.

Ms PEASE: Therefore, any staff who work in nursing—your members—would be required to have those? Are existing vaccinations in place?

Ms Dwyer: As part of their employment, that is—

Mr Prentice: Yes.

Ms PEASE: And make sure that they are maintained and up to date?

Mr Prentice: That is correct.

Ms PEASE: So the introduction of the mandatory vaccination for COVID is something that your members would be relatively familiar with, knowing that that is part of their code of conduct and capacity to be employed?

Mr Prentice: Yes.

Ms PEASE: So that is comfortable. How do you feel about the areas that are no longer going to be required to go through? We have already heard that there are three areas—that is, masks, the isolation and vaccination and also the quarantining. In terms of the other areas, are you comfortable with those that they no longer have to go through? Have you read about that? Health directives cannot introduce lockdowns or border closures. Do you have any comments around that?

Mr Prentice: I think in our submission we—

CHAIR: On page 4 you talk about restricting powers of the CHO and—

Mr Prentice: Yes. From a health professional perspective, rapidly being able to respond to a significant event such as a pandemic, which can often rapidly unfold, requires the ability of those who are tasked with that role such as the Chief Health Officer to respond very quickly and in a timely

manner to basically protect not just sectional groups within society but society as a whole. As we have indicated here we were broadly supportive of this, but I think we have pointed out also that the changes need to be evaluated at some point and potentially that is an area where we would be interested in seeing how, once this pandemic is over, that has transpired. Most importantly, our view would be that those charged with rapidly responding to future events must have the capacity to do so in broad terms.

Ms Dwyer: In our July submission we did elaborate or expand on that further to say that, in the context of perhaps where we sit now, some of the measures that have been in place and have been required to be in place may not be sustainable moving forward if we consider the impact that it has had. That has been fairly well publicised in different types of commentary. We have made a previous comment on that in our July submission that talked to the concerns around any of those types of directives moving forward in their capacity to be unsustainable for the community at large.

CHAIR: The Chief Health Officer articulated this morning that there is an ability to adapt and be agile around any changes that might occur based on the advice of the AHPPC or groups like ATAGI. I think he said quite well that this is a winding back but a just in case—

Mr Prentice: I think that pretty much well summarises it. The thing to bear in mind is that the next pandemic is guaranteed; it is not a maybe. We just do not know when it is going to come along. There is a pandemic cycle, I would imagine. We are in the tail end of that at the moment. For any future event we will be in the same place we were—I remember going to that first public briefing by the CHO—where we had no vaccine, no antivirals and in Australia at the time virtually no domestic capacity to manufacture personal protective equipment. While that hopefully is no longer going to be an issue, we certainly will be in that phase where there is not a lot more that we could do than those broad public health measures until specific treatments and vaccines become available. The ability to quickly respond to that evolving situation is, in our view, very important given that a future outbreak, for example, may have a much higher case fatality rate than COVID has had.

Mr MOLHOEK: We cannot rewrite the past. We have come through it. We have dealt with it as best we can and, I think, fairly well, all things considered. You touched on the need for things like surge planning and possible future pandemics. In relation to this bill has there been consultation between your union and Queensland Health or the government on some of the issues you flagged around the need for better planning around surges? Has there any discussion around how we can better manage or facilitate outpatient services and surgery and even the wellbeing of our workforce should there be a recurrence or another pandemic of some kind? In a sense, what debrief has there been between you and Queensland Health? What are some of your thoughts around how we can be better prepared and better equipped given your comments around the need for surge planning and just general support for this legislation?

Ms Dwyer: I could not speak to any of those particular debriefs. That certainly has not been within my immediate remit, but certainly at a broad level we have had many discussions with government and with Queensland Health over a fairly long period of time on many matters affected by COVID. Certainly, if the committee seeks any detail to those discussions we could take that back to our secretaries and seek further comment on that. To the matters affecting future workforce planning, wellbeing and patient flow, that sort of falls back to the first question from the member for Moggill in that there remains an opportunity to work on that in more detail now with the benefit of hindsight.

As we move into a more stable part of this pandemic, particularly over the forthcoming 12 months which is the extent of the current temporary measures, we would welcome any sort of engagement on that if there was any intent by government to put forward any proposals or plans around that. That is certainly something we would be able to continue to work through, but to any particular matters that we have may have discussed I might defer to Dan in the event that he has some additional knowledge. He does deal with other stakeholders.

Mr Prentice: I have been party to ongoing communication on a regular basis. For example, Queensland Health has a regular union update where unions which work in the health sphere are regularly updated around issues not just industrial but professional and other issues. That is a very useful forum. I should also commend Queensland Health for its aged-care COVID working group which I have been a member of. Again, that has been a very useful forum too, because that not only brings state representatives to the table but also PHNs, the Commonwealth Department of Health and the aged-care regulator. Those forums are very useful for sharing information and getting updates but also providing feedback about issues that we have may have found either at the system level or in relation to particular services.

I have been to two workshops over the course of this year that have been facilitated by Queensland Health—one around disability and the other around more generally the COVID response. Again, we have been very appreciative of being able to be a stakeholder in those discussions. It will take time to work through all the issues and learn the lessons from this pandemic. Certainly we would welcome the opportunity to be a constructive stakeholder in any of that.

The other thing to say is that even pre-pandemic there were a range of mechanisms that we as an organisation interfaced with, both public and private sector, in relation to issues around workforce, nursing and midwifery. For example, NaMIG, the Nursing and Midwifery Implementation Group, is an ongoing mechanism where a lot of those issues, particularly around workforce for example, can be discussed. Certainly our relationship with the Office of the Chief Nursing and Midwifery Officer is important there as well.

Mr MOLHOEK: As we sit here today, have there been any positive strides forward in terms of how we are going to address labour force shortages?

CHAIR: Before we go into that, we are at the end of time allocated and, as the deputy chair would know, we are starting to drift away from the bill a little. I am sure you were part of the workforce summit but you also made a significant submission to our formal work on primary and allied care. I think the witness has answered that in the formal submission. Of course, that has been tabled with significant recommendations which the government responded to. I do not want to drift away into the workforce side of it too much, with respect, deputy chair. Thank you for your contribution today.

Mr Prentice: Thank you.

COSTELLO, Mr Sean, Principal Lawyer, Queensland Human Rights Commission (via teleconference)

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

CHAIR: Good morning, Ms Holmes. Thank you for being here today and I thank the Human Rights Commission for its submission. You are welcome to make an opening statement before we move to questions.

Ms Holmes: Thank you. I first acknowledge the traditional owners of the land on which we meet today and pay my respects to elders past, present and emerging. I thank the committee very much for the opportunity to appear today. The bill implements many previous recommendations of the Queensland Human Rights Commission, and we are generally very supportive of the bill. We are particularly pleased to see that the bill clarifies how the Human Rights Act applies to the new framework, including providing for parliamentary scrutiny and that parliament may disallow public health directions. This process provides for the publication of information about why any limitations on human rights is reasonable and proportionate.

In our submission we suggest that further amendments should be considered and we highlight areas where further justification is required for limitations on human rights. In particular, we recommend that the government provide further justification for why the bill does not include mechanisms for a person to seek an independent review of how a public health direction applies, particularly to those subject to isolation or quarantine directions.

In relation to review rights, I see that Queensland Health in its submission states that the bill does not include a specific process for individuals to seek review of decisions made under public health directions; however, in administering the legislative provisions, the Chief Health Officer and Queensland Health must comply with relevant legal requirements, including requirements for natural justice and procedural fairness. Further, they say that the bill does not prevent a person from seeking a review under the Judicial Review Act 1991.

The Human Rights Commission is of the view that judicial review is not a timely, affordable or accessible means to seek independent review for a person in a hotel quarantine situation. By the time the court hears any application, they will be out of quarantine. If this power remains in the bill, it should be accompanied by an efficient, accessible and timely means to seek an independent review. Other states have put those mechanisms in place.

We also recommend the development of an accessible process for individuals to demonstrate they are exempt from a direction to avoid the confusion and confrontation we have observed to date, particularly regarding people exempted from wearing a face mask. Committee members may be familiar with this from their own constituents. There is a lack of understanding across the community of how exemptions work and when they apply. For example, we have seen instances of businesses asking for medical proof of exemption which is not required under the direction for the exemption to apply. The response from some businesses and employers has been to refuse service or discipline employees when they feel insufficient proof of an exemption has been provided.

In the commission of the 214 complaints about mask requirements we finalised in the financial year 2021-22, 38 were accepted as being a potential breach of the Anti-Discrimination Act, mostly on the basis of impairment discrimination. Many were due to a business not having a clear way of understanding who may have a legitimate exemption to wearing a mask.

We also suggest the government further justify several of the proposed amendments to the Corrective Services Act. On the information provided, we suggest that the Corrective Services Commission and its temporary powers should only be exercised in relation to COVID-19 and not any emergency. This is COVID-19 legislation—not any emergency legislation. We think those very extraordinary powers should be confined just to the COVID issues.

We also ask the committee, leading on from the comments and discussion with the last witness, to consider if the government should continue to consult with stakeholders and the broader community with a view to developing legislation to respond to other pandemics Queensland may face in the future—specific, fit-for-purpose pandemic legislation rather than the ongoing rolling over of legislation such as we have had in this pandemic. That would be our recommendation to the committee. Thank you very much.

CHAIR: We will move to questions.

Mr MOLHOEK: In your submission you talk a little about the different approach in Queensland versus, say, the Australian Capital Territory and Victoria. Could you elaborate on that a little?

Ms Holmes: I will hand over to my colleague, Mr Costello, who is on the line.

Mr Costello: Thank you to the committee for allowing me to appear remotely. To answer the question which, I understood, was about how the Queensland approach compared to that in Victoria and the ACT, obviously we are getting closer to those jurisdictions in this bill in terms of providing greater parliamentary oversight of the public health directions. To Neroli's final point in her opening statement, I suppose the key difference now is that in Victoria they have what is essentially permanent pandemic legislation which seeks to learn from the lessons we have all had since 2020 about governments responding to pandemics. That legislation does not just apply to COVID-19 but any pandemic situation. They have put in place some of the measures that are in this bill, but additionally others such as, as Neroli said in her opening statement, if someone is subject to some form of quarantine detention, regardless of the pandemic condition which has triggered the emergency, then they have a right of review through an independent officer in real time—within days of that detention direction being given to them. To answer the question, the key point would be that the Victorian legislation provides these powers and these safeguards for any pandemic into the future.

Mr MOLHOEK: You also made a comment in your submission about the role of elected representatives versus the role of the CHO. Could you elaborate on that a little for the public record?

Mr Costello: Sorry, I should have also referred to that. In both the ACT and Victoria essentially the chief minister or the Premier, if you like, enlivens the powers by declaring in some way that an emergency situation exists and that creates a cascading down suite of powers. In some cases they are exercised by a minister and then going down from there to the Chief Health Officer.

As I said, in Victoria that is a long-term approach. In this bill the Queensland government has taken the approach that we are being specific to COVID and so is extending the legislation for only 12 months to respond to COVID. An observation we made in our submission is that that may be a reasonable safeguard, but as we have seen with this legislation to date often it is extended. Certainly, if that were the case here, we are suggesting that it would preferable if these powers were with an elected official as is the case in Victoria and ACT. Then the Chief Health Officer exercises those powers. Equally, the Premier, for example, would switch off the powers when the decision is made that the emergency has come to an end.

Ms Holmes: The cascading powers are around the impacts on the whole community. In Victoria the closing of borders and the big powers that have statewide impacts are the ones that need to be invoked by the elected representative. The powers more immediate to individuals are the ones that are more customarily given to the Chief Health Officer. Communicable diseases and things like that where you are talking about an individual being asked to do something remain with the Chief Health Officer. Those very large statewide decisions that have an impact on the whole community are, in our view, best exercised by an elected representative rather than by the Chief Health Officer.

CHAIR: Ms Holmes, we had the Chief Health Officer, Dr John Gerrard, talk about this this morning. He no longer has the capability to make calls on border closures. He can make calls around isolation, masks and vaccines.

Ms Holmes: That is appropriate. This was talking about future legislation—fit-for-purpose legislation that I think the question was pertaining to. That is true in relation to this bill. The powers have been substantially carved back. If we are looking at how we act in the future—as the last speaker said, we will have another pandemic—we have learnt a lot through this pandemic so we are talking about trying to create a new raft of legislation in the future that customises the powers to different roles and responsibilities in an elected democratic situation.

CHAIR: I think you said that you had 214 complaints in the last two years around—

Ms Holmes: That was around mask wearing. We have had many more complaints than that about hotel quarantine and vaccination. There is considerable confusion in the community about masks. Very understandably, the directions did change quite frequently. I know Queensland Health tried very hard to keep their website accessible and updated, but it was a challenge. We tried to do that on our own website to inform people of the requirement at any particular point in time. Obviously, businesses do not have time to look at websites all the time and to understand in intimate detail what directions mean.

The exemptions from wearing a mask did not require any specific proof or evidence for a person who is legitimately exempt from wearing a mask to be shown to a business—whether you are going into your pharmacy, your doctor's surgery, your supermarket or your little business down the road. Unfortunately, sometimes the business owners felt obliged to police that. That resulted in complaints and sometimes complaints that are legitimate complaints under the Anti-Discrimination Act. We did not accept a very large number of complaints because they were just 'I do not want to wear a mask'. That was not a legitimate excuse or exemption. If you could not wear a mask for health reasons—

and there are a certain number of people in the community who cannot wear masks—that is a legitimate and bona fide exemption, but businesses did not know that and could not make that evaluation. Sometimes it ended in confrontation between businesses and customers.

We think there could be a better way of managing that in the future. That is a learning that we think has come out of this. I know that all the human rights agencies have written to the health minister at a federal level to try to get a uniform approach to that so that people know and can easily see that a person is excused from wearing a mask which avoids confrontation and having to justify not wearing a mask to a business owner. Having to disclose quite personal and intimate health information is not appropriate. It is better to have a simple signifier that it is a bona fide exemption that a person has.

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

Mr ANDREW: There are a lot of those human rights issues in this bill. There are sunset clauses and a lot of safeguard provisions in it. To take it a step further, given the member for Lytton's questions about mandatory vaccines to the nurses' union, has the Human Rights Commission with the scientific community had a look at the situation where people have not been vaccinated but have serology tests with high antibody counts. Obviously they have not boosted, boosted, boosted to keep antibodies up. Are we violating the human rights of people who have good serology tests as far as antibodies are concerned? Should we not from a human rights point of view be allowing these people to integrate back into their workplace and back into society?

Ms Holmes: The Human Rights Commission is not medically qualified to comment on particular individuals or those sorts of issues. There are legal proceedings going on at the moment—a judicial review—where people who have objections to mandatory vaccination are taking their matters through the court. They are unfortunately going very slowly. Some of them are police officers, some of them are nurses and some of them are teachers. Mr Costello would be able to speak in greater detail about this. We have certainly intervened in cases to put the human rights angle to the court about when it is legitimate and proportionate to expect different organisations to mandate mask wearing by employees. Our observation is that as the pandemic progresses mandates sometimes become less justifiable as the virus, on medical evidence, becomes less virulent and less dangerous. Mr Costello, do you want to add anything to that?

CHAIR: Could we make it brief because we have other witnesses appearing very shortly.

Mr Costello: Further to Neroli's comments, I would note that generally the way the Human Rights Act operates is that the entity, usually the government, which is limiting rights, for example, through a vaccine mandate has the burden of showing that it is reasonable and proportionate. To the member's question, it is better put to the government if that is a less restrictive option that should be considered or an exemption to the direction. As I understood the question, are serology results a demonstration or a less restrictive option than a very hard and fast mandate.

Mr ANDREW: Correct.

CHAIR: Thank you very much, Mr Costello. I thank the deputy commissioner for being here and I thank you both for your contribution.

BENEDET, Mr Gerard, Branch Director, Pharmacy Guild of Australia

SEETO, Ms Amanda, Queensland Branch Vice-President and Committee Member for Brisbane, Pharmacy Guild of Australia

CHAIR: I now welcome representatives from the Pharmacy Guild. Thank you for your submission. Would you like to make an opening statement and then we will move to question?

Ms Seeto: We would like to make an opening statement. My name is Amanda Seeto. I am a Queensland pharmacist, pharmacy owner and vice-president of the Pharmacy Guild of Australia Queensland branch. Joining me today is Gerard Benedet, Branch Director of the Pharmacy Guild of Australia Queensland. We would like to start by acknowledging the traditional owners, the Turrbal and Jagera people, and pay our respects to elders past, present and emerging. We extend this acknowledgement to any First Nation people in attendance today.

I would like to start by thanking the committee for the opportunity to provide the following opening statement to the inquiry into the Public Health and Other Legislation (COVID-19 Management) Amendment Bill 2022. Firstly, the guild commends the government and the government agencies for their overall response to the COVID-19 pandemic. The positive position we find ourselves in today is due to the government's approach of listening to the medical experts and taking a proactive and rapid response to implementing measures to protect all Queenslanders. The guild supports the proposed temporary amendments in the bill—moving from the current emergency order framework to a more targeted, transparent and time limited set of powers which will assist in managing COVID-19 outside of a declared public health emergency.

Community pharmacy has been a key partner to the government in the fight against COVID-19. We have stayed open, we have continued to provide in-person health services when other providers would not and we have ensured patients had ongoing access to medicines as well as being a source of education, trusted advice and reassurance for all Queenslanders—not to mention our now recognised public health role in delivering over 1.7 million COVID-19 vaccines to Queenslanders. This level of essential service delivery would not have been possible without key legislative and regulatory advancements in pharmacy practice made via emergency orders under section 58 of the Medicines and Poisons Act 2019.

Emergency orders are only permitted to be made by the chief executive in certain situations, including during a declared public health emergency under the Public Health Act 2005. When the declared public health emergency ends so do these advancements. We have raised our concerns about the loss of these commonsense improvements in a community pharmacist's scope of practice with Queensland Health. We are yet to receive confirmation of their plans. The department's report to this committee states—

Queensland Health notes the issues raised by the Pharmacy Guild of Australia are under consideration and will be the subject of separate consultation in due course.

We are somewhat disappointed in the department's response given the issues raised are not controversial and are in the best interests of patients. It is hard to understand why the department has the ability to change legislation without doing the necessary policy work to ensure we do not lose the advancements already in place—advancements which are safe, based on a patient's best interest and increases access to high-quality health care. The risk of going backwards is real.

What do Queenslanders lose when the emergency orders cease to exist and whilst the department undergoes this separate consultation process? There are five things to potentially lose. First, to get an influenza vaccination in a community pharmacy you will have to be over the age of 10 years rather than currently five years and over. Second, to get a COVID-19 vaccination in a community pharmacy you will have to be 16 years and over rather than five years and over. My personal experience has been that families have enjoyed the convenience of easily booking in their COVID-19 and/or influenza vaccination appointments for the whole family in one go in an environment that is familiar to children rather than needing to make an appointment for their child under 10 to visit the GP for their flu vaccination. Repealing this access afforded under the emergency orders will create confusion for parents and caregivers come the next flu season.

The third loss is that a community pharmacist will no longer be able to give vaccinations outside of the four walls of the community pharmacy. Fourth, trainee pharmacists or pharmacy students who have undertaken the relevant training will not be able to administer a vaccination without another pharmacist standing directly with them regardless of how long this trainee has been in training. This is despite trainee pharmacists and many other trainee health professionals vaccinating throughout

the pandemic. As the health workforce shortages remain critical, it makes sense to allow immunising pharmacists to continue to determine the level of supervision that a trainee pharmacist requires to administer vaccinations.

The fifth loss under the cessation of emergency provisions is that patients will no longer be able to access an original pack of their regular medication in times of emergency, rather they will only be able to access a limited three days supply. A pandemic is not the only time a patient may seek an emergency supply of their medication without a prescription. Natural disasters undoubtedly will still occur and, sadly, there will still be individuals escaping domestic violence. Accessing a GP appointment within three days is seldom a priority for people in these situations, notwithstanding the lack of availability of a GP appointment in that time frame, especially in regional and remote areas. What do these patients do when their three-day supply runs out? They head to the emergency department. Preventable hospital presentation data shows that is where they go often. If not, they simply go without their medication. Thus the cycle of poor management of chronic health conditions continues for these vulnerable people.

As a community pharmacist, I cannot fathom why these common-sense regulatory changes which are safe, provided by trained pharmacists, have improved access to medicines and services, and are currently available have not been enabled permanently. These are all excellent advancements but it seems we are in limbo once again while the department potentially seeks to go backwards. The guild understands that this inquiry is focused on the Public Health Act 2005, but we feel it imperative to draw the committee's attention to the consequences of ending the declared public health emergency without further consideration of legislative or regulatory instruments enabled during the public health emergency.

Patients expect that policymakers and decision-makers endorse, communicate and support the clear public health role of community pharmacists. To do so, this committee in its final report could call for the permanent enabling of these common-sense public health services, giving Queenslanders greater healthcare access and better services. Such a position would give patients and pharmacies certainty moving forward and to ensure that there are no adverse consequences from the Public Health and Other Legislation (COVID-19 Management) Amendment Bill 2022.

As I stated earlier, the guild supports the proposed temporary amendments in the bill moving from the current emergency order framework to a targeted, transparent and time limited set of powers which will assist in managing COVID-19 outside of a declared public health emergency, but this does not mean going back to the old rules—the outdated, the backwards, the nonsensical rules which preceded the pandemic.

We all recognise the pressure which has built up in the health system during the pandemic, whether it is the inability for patients to get a GP appointment, ambulance ramping, preventable hospital presentations or the rise of chronic disease in the community. It makes no sense to enable health professionals like pharmacists to do more during a pandemic only to send them backwards in terms of how they can help patients at a time of massive demand.

This would be a clear and adverse consequence of the Public Health and Other Legislation (COVID-19 Management) Amendment Bill 2022 if policymakers do not commit to the continuation of services in question. This is not just a pharmacist issue. Other health professionals are in the same, if not similar, situation. They should not go backwards after having their shoulder to the wheel during the pandemic. We are happy to now take questions that you may have.

CHAIR: Thank you very much, Ms Seeto. The guild raises some very valid points. We have done some previous work on the pressures on our emergency departments in the primary care space. On the supply issue alone that you just raised, as a regional member, I know that you are absolutely right. Even my colleagues in South-East Queensland know about dealing with natural disasters. I think you raise some valid points particularly around ongoing influenza vaccinations or further boosters if they are required in this space.

I want to start by commending our pharmacy workforce. It is MPs like me who encouraged our community to get out there and get vaccinated. In fact, I took my entire family to my community pharmacy to get the last boosters. Thank you for the enormous contribution—1.7 million vaccines is significant in making sure people were kept safe throughout the pandemic.

We do have the department back in front of us this afternoon. I will be keen to hear from them on some of those points that you have raised. I will open it up to questions. I want you to understand that the guild and community pharmacies have done a significant job in helping to manage the pandemic. Thank you.

Ms Seeto: Thank you, Chair.

Mr MOLHOEK: I echo the chair's sentiments around the ongoing role of community pharmacies. It has been an incredible effort. I recall wandering into a pharmacy in my electorate very early during the pandemic and seeing the consternation of both customers and staff around the uncertainty. It was a very challenging time for everyone. I have had all of my shots at my local pharmacy. I am very grateful for their work and their accommodation of my requests sometimes at odd hours to try to get in.

In your submission you talk about the emergency orders and the difference between schedule 4 and schedule 8 medicines. What are the substantive differences between schedule 4 and schedule 8 medicines? Why is there a provision that you can only release a three-day supply at a time? I understand the effect of that in terms of breaking packs, but I am curious as to what the difference is.

Ms Seeto: The difference between a schedule 4 and a schedule 8 medicine?

Mr MOLHOEK: Yes.

Ms Seeto: A schedule 8 medicine comes under the category of monitored medicines including potentially medicines of addiction. The continuance measures have been applied only to schedule 4 non-monitored medicines because they are essential for patients' chronic disease management, whereas schedule 8 medicines are less likely and require more stringent framework around their supply.

Mr MOLHOEK: In respect of the requirements, where it talks about a pharmacist can confirm the continuation of supply even without a script if there is a pattern there, do you see that as an important measure moving forward? A lot has changed during the pandemic. You can ring your doctor and they will send you a text message with your script and then you walk in and show them the QR code and away you go.

Ms Seeto: Under the measures for supply of continued dispensing of medicines, there are some rules that apply. The patient must be stable and on their medicines and we must be able to assure ourselves of that before we supply the medicines such as a recent patient history, contacting their regular pharmacy if they are from out of town or perhaps their My Health Record. Also the supply of medicines under the continued dispensing measure is only allowed to happen once every 12 months, so it is not something that a patient can access on a continual basis. It is giving them the opportunity in the case of emergency when they have run out of medicines to continue their therapy and give them adequate time to see their GP for a new prescription.

Ms PEASE: I would also like to acknowledge the great work of community pharmacies. Like my colleagues, I have had my booster shots and my flu vaccination at my community pharmacy, as my little grandson who lives with me has. I am really interested to hear if you have any data to support your comments around the take-up of the original pack when people have not been able to access prescriptions. We talked about the original pack rather than the three-day supply—things that are going to be impacted when the direction ceases. Do you have any data that would support the number of people who would have come through pharmacies to pick that up?

Ms Seeto: There is some data available. We can take that on notice. We have data on the volume of medicines that have been supplied to patients under the continued dispensing measure throughout the pandemic. You will be able to see that difference in that data.

Ms PEASE: That would be great. As you say, it was a great initiative and it served the community very well. We saw that. To be able to provide some good data around that is a really good way to support any consideration of that going forward, particularly around the fact that, as you have said, you can only get it once every 12 months. My sister was a beneficiary of that. She did not have a script with her. She could not get there to her local community pharmacy because of floodwaters. I give a shout-out to Peter Evans from our Wynnum Day & Night Pharmacy. He was able to contact her doctor and the local pharmacy in Cooroy to get that sorted. It was a great way to be able to help her to get her medication. It would be good to see that continue. Providing some data would be a good way for us to take that matter up for you.

I have no further questions but I do want to say thank you for the great work you have done and that all of our community pharmacies do. I have some great community pharmacies in Wynnum. I want to acknowledge all the great work they do and thank them for the care of our community not just in terms of dispensing medication but in genuinely caring and for their capacity to visit residents on site to provide immunisation when people might not necessarily be able to go to the pharmacy. Thank you very much for the great work.

Mr ANDREW: Thank you for all the work the Pharmacy Guild do throughout the region. Could you elaborate on the rise of chronic diseases in the community you mentioned in your opening statement? Could you expand on that so we can understand what those chronic diseases are and what you are seeing out there?

Ms Seeto: Could I clarify that this is in terms of the three-day supply and then the cycle of care of patients who have chronic diseases and how they are managed?

Mr ANDREW: Can you drill down on what chronic diseases you are seeing an increase in across the board?

CHAIR: It is similar to the former question around data. I think the guild is going to provide some data around that, member. Do you have another question?

Mr ANDREW: No. That was the only thing I wanted to ask about.

CHAIR: We have time for one more question.

Mr MOLHOEK: In your submission you make a statement that the CHO's 'public health directions assist community pharmacies with implementing these requirements by providing a clear legal basis for them to do so'. Could you explain that a little more?

Mr Benedet: That is more in relation to mask mandates and also in relation to the mandates around staff needing to have been vaccinated. Employment law is a little tricky in that instance without a public health emergency declaration to that effect from the CHO. That is what that comment was in reference to.

CHAIR: There was a question taken on notice. Can we have that response back by 10 am on Tuesday, 4 October? That will help us in our deliberations. Thank you very much.

Proceedings suspended from 11.29 am to 11.42 am.

DUNN, Mr Matt, General Manager, Advocacy, Guidance and Governance, Queensland Law Society

HUDSON-FLUX, Mr Yale, Graduate Solicitor, Queensland Law Society

THOMSON, Ms Kara, President, Queensland Law Society

CHAIR: I welcome Ms Laura Gerber, who is standing in for the member for Bonney. If you would like, you may make an opening statement after which we will have questions for you.

Ms Thomson: I would firstly like to thank the committee for inviting the Law Society to appear at this public hearing this morning. We are especially pleased to be in the red chamber. I respectfully recognise the traditional owners of the land on which this hearing is taking place here in Meeanjin and pay my respects to the Turrbal and Jagera nations. I also pay my respects to all elders past, present and emerging.

The Law Society commends the government for its implementation of a legislative framework to respond to the COVID-19 pandemic. We also acknowledge the need to review the legislative framework to ensure that it remains fit for purpose and the consultation process now engaged in to determine whether it is appropriate to extend or modify the measures for a further 12 months. I wish to make a brief opening statement on behalf of the Law Society before the committee asks questions of us.

Under the Public Health Act it is proposed that the Chief Health Officer or Queensland Health will determine when COVID-19 poses a serious risk to the public health system or community to trigger the making of a public health direction. Whilst we acknowledge there is a necessary multifactorial approach for the determination of what might be a serious risk, it is the Law Society's view there ought to be some clarity or certainty around what that is and what it refers to. That clarity or certainty could take the form of a definition of what constitutes a serious risk or perhaps reflective of how the landscape may rapidly change in these circumstances. Perhaps it could form part of a published justification statement so there is transparency in relation to what factors have influenced the direction being made.

The Law Society has some difficulties with the proposed amendments to the Corrective Services Act which I will briefly speak to. The Law Society does not support making directions that relate to visitor restrictions in their proposed form. It is proposed that such restrictions could be imposed in the absence of a public health emergency declaration. This could be in circumstances where similar restrictions are not applicable in other facilities such as aged care or other vulnerable settings. The proposal to allow restrictions to remain in place for 90 days does not, in our view, reflect a targeted approach to managing COVID-19 in correctional facilities. We say there must be a recognition that such measures need to be carefully balanced against access to justice issues and ensure that the justice system can continue efficiently and effectively. The Law Society recommends that consideration be given to reducing the restriction to 30 days, which is equivalent to six isolation cycles, as opposed to 18, which is what is currently proposed.

As you mentioned, Chair, I am joined today by Matt Dunn, the Law Society's General Manager of Advocacy, Guidance and Governance, and Yale Hudson-Flux, who is a graduate solicitor. Both are happy to take specific questions from the committee today.

CHAIR: I am unsure whether you heard the Chief Health Officer's contribution this morning. He certainly addressed responding to what is deemed a serious risk, and you will be able to see that in *Hansard*. A lot of what he said was based on advice from the AHPPC, the impact on staffing and a number of other factors. You are welcome to review his statement in that particular instance. I will move to questions.

Mrs GERBER: Welcome. Thank you for your oral and written submissions. Part of your recommendation was for there to be a process for a person to seek an exemption to a direction or requirement. I am interested in how you envision that might work. I am interested in unpacking that a bit more.

Mr Hudson-Flux: We do not have a particular process to suggest. We would just reiterate that it is important to have one in place that is flexible enough to capture vulnerable cohorts, perhaps automatically, and then assess certain cases on a case-by-case basis.

Mrs GERBER: How did you envisage the exemption process might work while it is being considered? So a direction has been given and there is a category of people who want to apply for an exemption. How do you envisage that direction might apply to that category of people who are potentially captured by an exemption process?

Mr Dunn: I will try to answer that question. Obviously any consideration would need to be done reasonably rapidly. I know in Victoria, with their oversight of detention and isolation matters, there are quite strict time frames for these decisions to be taken in 24 hours, and 72 hours in review, so there would need to be quite an expedited process for that. I think at previous hearings we have mentioned potentially some type of expedited process might be able to be done through the Department of Health as an internal review mechanism, perhaps even in some type of special process set apart through QCAT for external review potentially, but certainly there are some policy issues for the government to sort out in such an exemption about whether the effect of a direction should be withheld for someone who has sought an exemption or whether it should be in place. In this context, if we are dealing with public health crises, there may well be a bias that the direction should apply until there is an exemption because of that overriding public health purpose. In a different policy context, you might turn the bias around the other way for other reasons, but in this context you may well choose to do it in that particular method and then exempt people from the requirements that way.

We understand that Queensland Health also indicated that there would be class exemptions or certain person-type exemptions with any public health direction made so that certain types of people were already exempted automatically from the operation of a direction. There could well be a number of circumstances where particular persons, cases, circumstances or their personal situation required some type of deviation from that direction for particular reasons. We have seen in the past people who are in isolation from funerals of loved ones and other such things that need to be gotten to. There needs to be some flexibility there to be able to deal with those individual circumstances on their particular merits, but also dealt with reasonably quickly.

Mr SMITH: I will go back to what the chair first suggested early on about the definition of ‘serious risk’. I understand that any time that we are talking about language, we are talking about semantics and so forth. Would the Queensland Law Society have a definition of what they would like to see as ‘serious risk’ in a medical context?

Mr Hudson-Flux: We do not propose a specific definition. We envisioned an inclusive definition in the bill the matters listed in the explanatory note and Queensland Health’s response—so the epidemiological data and current responses—and it lists what is considered in that context by the Chief Health Officer, but we do not have any specific wording.

Mr SMITH: Would you expect there to be a criteria of sorts to say, ‘This is a serious risk, this is a serious risk and this is not’?

Mr Hudson-Flux: Yes, it would be an inclusive definition of what would be considered as part of that assessment. What is flagged in the explanatory note and Queensland Health’s response seems appropriate and consistent with the objective here to enact transparent directions.

Mr Dunn: To add to that, obviously the decision about what trips the threshold of being a serious risk would be a medical decision on a public health basis—it needs to be informed—but even the Chief Health Officer identified a number of those indicia which really should be considered in making that decision. It would not necessarily be a troublesome thing to set out, as my colleague indicated, in a definition to say that these would be some of the elements but not necessarily all of the elements that should be considered in coming to that threshold decision. Then it would be really useful, as our president said, for the justification statement to step through those considerations in terms of then the publication.

Mr SMITH: I suppose a risk of a potential criteria, though, would then perhaps be a determination around different criteria would be based on a verb that is being used. There would be a difference between ‘risk’ and ‘serious risk’ as there would be when you allocate through a criteria. Does that not then create even a greater argument of semantics? The chair talks about his days as a paramedic. In my days as a teacher, there is a difference between A, B, C and D based around the changing of a verb to a noun. Are we not now opening ourselves up to a greater argument of semantics if we put forward a criteria instead of just using that justification statement within those five days as a determining factor as to whether or not the parliament would consider it to be a serious risk or not?

Mr Dunn: I will be happy to venture an answer to that question if I can. If the parliament chooses to enact the legislation with the threshold of ‘serious risk’, then at the risk of playing semantics—and I guess we are lawyers so we are inclined to do that—

Mr SMITH: And future lawyers.

Mr Dunn: Indeed, but if we are talking a threshold requirement of serious risk then we are talking about something which needs to be more substantive than just simply risk. We are talking about parliament’s intention to put this at a threshold level which has some seriousness to it, some

significance to it, something that is more meaty than simply there is a possibility that something might happen which would be more risky. We are looking at a serious risk. We want to see something that is a bit further, that is more extended than simply the potentiality, or we want to see the potentiality of something quite terrible happening. We want to kick it up a level, which is why the drafting is around 'serious risk' which is a good drafting narrative. The Law Society's submission is that in order to be able to clearly differentiate what that serious risk should be, and give some guidance around those decisions, is some of the types of things that could or should be included in making that decision so that it is more transparent for those who have their rights or their liberties curtailed because of the legitimate public health requirement, understanding why the CHO has come to that decision and where the balance of those factors are. There will certainly be in any list, which is as my colleague said, an inclusive list, so that is not necessarily meaning that if there is something not in that list it cannot be considered. We would suggest having a list of things that could or should be considered.

There will certainly be different weightings in any particular factual scenario. The advice from ATAGI may well be very important in one particular circumstance. The nature of the spread or the containment of a particular outbreak might be important. There will be different factors that should be given different amounts of weight. We cannot necessarily say that there should be one complete prescription, but we know the types of elements which will go into making that decision, and we are saying that there should be more transparency around what are those types of elements so that the public fully understands why that public health direction has been made.

Mr SMITH: I appreciate that, Mr Dunn. I think maybe what could potentially be looked at more than a set of criteria may be principle statements and then the principle statements need to be put forward in that justification. That way you can consider the differences between the medical factors and then the sociocultural context as well. Perhaps principle statements or value statements may be a better outcome than a set list of criteria and boxes that needed to be ticked off potentially?

Ms Thomson: Possibly, yes. One way legislation often deals with these sorts of things is to say that consideration 'may be given' to various factors rather than 'shall be given' to various factors, so that might be a drafting issue that can cover off on that.

CHAIR: I have some views: in CHO we trust to make the right decisions based on all the advice that he receives.

Mr ANDREW: I thank the Law Society for coming in. What are your thoughts, please, on the emergency powers being wielded by different officers coming up to the Public Service as opposed to elected and accountable officials such as the ministers?

CHAIR: You are starting to weigh into opinions. I am going to allow some latitude. I think what you are trying to ask is, correct me if I am wrong, that the CHO does not make the decisions on border closures and things like that; it is up to the minister. Is that where you are going, member?

Mr ANDREW: I was asking the QLS about the emergency powers bill being wielded by some of the officers of the Public Service as opposed to elected and accountable officials such as the minister. That is what I wanted to get to the core of, Chair.

Mr SMITH: Chair, I think perhaps he is asking about the legislative soundness of public officials making those decisions instead of—is it legislatively sound that the CHO would make decisions under these powers, I think.

CHAIR: I will allow some latitude in your response.

Mr Dunn: It is certainly not unprecedented for government officers, public servants, to make decisions under powers that are delegated to them by legislation. That is the normal operation of government. The parliament provides the source of power under the Constitution. That then is given and delegated to particular responsible officers who have certain responsibilities and obligations in terms of using those powers. There are certain threshold requirements for them to make those decisions, and we have just been discussing that with respect to 'serious risk'. That is a very normal and very usual part of our system of government and the delegation of power in the circumstances. Certainly in terms of the CHO in making the public health directions under the Public Health Act, that is a very normal and ordinary part of our system of government and not something that is particularly strange or unusual. I think it is a very good move that in the bill, as we have said in our submissions, that there is now more oversight of those particular decisions and they come back within the fold of the subordinate legislation to be reviewed by committee and have disallowance motions. That then increases that oversight of the parliament ultimately where the power springs from, and then the transparency, oversight and accountability comes through from that. That is certainly a normal part of our system.

Mr MOLHOEK: I want to go back to this question around serious risk. I think we agree it would be incredibly difficult to come up with a definition that covered every contingency which leads me almost to the member for Mirani's question, and that is that there are differences between COVID legislation in some of the southern states and here, and that is that there is a cascading of powers. In effect, it actually is the elected representative that declares the health emergency and then that enables the Chief Health Officer and others to enact other powers and actions. Do you think that that would be a way of better dealing with it? Should the parliament deal with the question of serious risk at the time and debate that more fulsomely before the declarations are made?

CHAIR: That is seeking an opinion, but I will allow some latitude in that it is the final question.

Mr Dunn: Thank you, member, for the question. Certainly by the introduction of a disallowance motion, the parliament then does have the opportunity to have the discussion—or at least the parliamentary committee and the parliament itself—about whether there is the threshold requirement triggered in a particular circumstance, so there is that parliamentary oversight in terms of the ability there. It does come in the circumstances—

Mr MOLHOEK: Sort of after the fact.

Mr Dunn: I understand what you are saying with respect to it being an exercise of ministerial direction to issue the health direction rather than the Chief Health Officer, and that is another way it could be done in the circumstances. Probably the complicating factor in this circumstance from a policy perspective is you are dealing with public health emergencies which are themselves very medically related and very public health related and there are not a lot of ministers of the Crown who have a deep experience and medical qualification in public health, so in that context the health minister in making the direction would be almost entirely relying on the advice of the Chief Health Officer or otherwise in order to make a declaration or otherwise. It could be set up in that way. There is nothing wrong with an approach like that. It probably does not add a significant amount of oversight and a significant amount of check and balance in preference to the instruments that are made coming before the parliament and having the opportunity to be reviewed by a committee and to be disallowed as any subordinate legislation does.

If you wanted a different model, you could have it so that the Governor in Council needed to make the directions like with any other piece of regulation or otherwise if that was the approach that was wanted. I suppose in the circumstances the reason public health acts tend to take those approaches of being quick is because there is an immediate crisis that needs some type of intervention and the great balance is trying to balance that public health need with appropriate checks and balances and transparency in order to be able to ensure that the rule of law is appropriately respected, and that in the public health context is always that little bit more difficult perhaps than it is in some of the other policy contexts.

Mr MOLHOEK: So—

CHAIR: Sorry, Deputy Chair, but we are out of time. We have the Prisoners' Legal Service waiting to come to the table. I thank the Queensland Law Society for your contributions and responses to our questions today.

Mr Dunn: Thank you.

KRULIN, Ms Vanessa, Acting Principal Solicitor, Prisoners' Legal Service

CHAIR: Welcome and good afternoon, Ms Krulin. Thank you for being here today. Would you like to make an opening statement before we go to questions?

Ms Krulin: Yes. Thank you so much, Chair, and thank you for the opportunity to speak with the committee today. I would like to first start by respectfully acknowledging the traditional owners of the land and pay my respects to elders past and present and acknowledge their wisdom and contribution as protectors of Meanjin. Prisoners' Legal Service is a community legal centre. We have operated for about 30 years. We operate prison visits and give other advice, human rights included. We also have a small community legal education function. We are a very small team—four solicitors, one who is generously seconded from a law firm, who provide legal advice to the over 9,300 prisoners in custody across Queensland. It is also supported by a team of barristers including Senior Counsel, who often provide their expertise on a pro bono basis, as well as with the support of volunteer lawyers and students.

We would like to acknowledge the government's efforts to step down restrictions and other measures introduced as required at certain points of the COVID-19 pandemic. We do have strong concerns about the exception of these measures in the bill affecting the Corrective Services Act for which there is no similar step down. Rather, the bill seeks to extend the extraordinary powers of the commissioner of Queensland Corrective Services and this is despite all other material regarding the information and the intention of the bill to be about a lessened risk associated with COVID-19, including why less restrictive measures should be permitted. We acknowledge and endorse the comments made by the QHRC, the Human Rights Commission, and I also acknowledge the comments made just now by the Queensland Law Society, both of which have raised concerns about the proposed amendments to the Corrective Services Act. These mirror our position that the proposed extension to permit lockdowns for up to 90 days is not justified. Our concerns are mostly set out in our submission to the committee. The implications that will continue to flow on from these powers allowing such extended periods of lockdowns are serious for prisoners, for their families and in our view for correctional staff also.

I would like to share an example of the feedback that PLS has received associated with lockdowns in the pandemic because I think it paints a good picture. This particular person was transferred from the Brisbane Correctional Centre to Woodford. We received this feedback in April of this year and there has been a lot like this. He was initially put into lockdown for eight days and then he started getting half-days out of lockdown after that. The person he was transferred with did test positive to COVID, but he was never tested. At this point he was triple vaccinated and he reported that everyone he was coming into contact with was similarly vaccinated, including staff. At Woodford they have 50-man units. If one person in the unit tests positive, the whole unit is locked down. The problem is that people continue to test positive and the whole unit continues to be locked down.

The conditions of a lockdown could mean that on some days there is a half-day release from the cell, and in this case that meant that from 9 to 12 each morning there were 25 people sharing a small exercise yard with two phones to make phone calls. They are not able to leave the unit to receive legal calls or attend rehabilitation programs which are often deemed necessary by the Parole Board to secure their release on supervised parole. They also missed work and medical appointments. There was one person who had his long-awaited medical appointment cancelled because he was not allowed to leave the unit and there have also been reports of missing medication.

On some days they stay locked down simply because there are not enough officers. This has caused riots in some cases. People do crazy things to get out of the unit—smash windows—but then the detention unit in this case was also full, so they are just moved to another unit and the process starts again. Although the GM did come and speak to the prisoners about what was happening and talked about policies, it does not appear that the policies to manage it were in place or able to be put in place; that is unclear. There were no special measures offered at all to ensure that supports were continued.

I want to mention the particular impact that this has on persons with disability. We know that at least 50 per cent of prisoners in Queensland have a disability. Most of these are cognitive impairments, acquired brain injuries, neurodiverse conditions such as autism and other psychosocial disabilities. This is a significant percentage, but the information that PLS received indicates that the number is probably much higher than 50 per cent. It is very difficult for most of these prisoners because the circumstances of their lives have not allowed them access to the supports and diagnosis that we would hope to have in the community and through traumatic childhoods, so many of them just do not know what is happening.

There will be a real impact for these, and I will finish by mentioning the problem with programs. The rehabilitation programs are often deemed as a requirement by the Parole Board for persons who are otherwise eligible for parole. If they have not done the program because they are locked down or they cannot be transferred to a centre that runs the program, they will just continue to not meet their parole requirements, and this has a particular effect on First Nations people who are overrepresented. Thank you.

CHAIR: Thank you, Ms Krulin. We heard from Mr Tom Humphreys, the Acting Assistant Commissioner, this morning about the complexities of managing COVID within a correctional facility, and it did sound very complex and difficult and we understand that a lot of people are affected. In reading your submission, you do have concerns around the lack of limitations and external oversight of these powers. You also mention that you hold a reasonable belief that a situation may exist at the prison, or in part of the prison, that threatens or is likely to threaten the good order and security of the prison, so I would ask you to just expand on that a little bit if you can. That is on the second page of your submission.

Ms Krulin: The point that I am making there is that in every other aspect of this bill—and there was a discussion about the appropriateness of who the decision-maker is with the Queensland Law Society just now—is that the rightful intention and the supported intention of the bill is the government's intention to step down the process and therefore to better scrutinise the decision-maker. We do not have a firm view about the discussion that just happened, but in this case it still sits within corrections with the commissioner. Prisons are a closed environment. We know that prisons are already significantly over capacity. There is not appropriate justification for the continuation of these powers without at least similar oversight to what has been offered in relation to other institutions that the bill will affect. That is the point that I am making there.

CHAIR: Okay. Thank you.

Mrs GERBER: Thank you for your oral submission and your written submission. Can you step us through some of those oversight measures that other institutions have been offered that you would like to see in the correctional facilities?

Ms Krulin: I cannot comment specifically or I do not want to take a strong position on how it works with other institutions. I think the main point is that if we leave it to the institution itself there is a risk that in those closed environments—whether that is disability accommodation or an aged-care facility or a prison—there will not be appropriate oversight of how it is managed. In the case of the corrective services proposed amendments, it is another significant step back. On that point, why is it 90 days still where it steps down in other aspects? We all acknowledge that prisons are very vulnerable environments, as are other types of institutions. We do not quite know, but we have a good idea of the percentage of prisoners who have disability. Why is it still at 90 days? I could not find any justification for that significant period of time in any of the material, and I note that the QHRC and the QLS have said the same.

Mrs GERBER: As a follow-up question to that, we just heard from the QLS suggesting that 90 days perhaps should be reduced to 60 days. I am interested in your view on that.

Ms Krulin: I think it would be better. It would at least be a step down. I would be interested as to why it could not be 30 days and I would be interested to hear not just from corrective services but also from the government more generally as to how this is intended to be stepped down in a correctional environment. I also note that, yes, this is a temporary measure and this is proposed until October 2023, but I think that we are all agreed that it could continue beyond that.

Mr SMITH: You might have just alluded to it then—and I do not at all doubt that the number of prisoners with some form of disability or cognitive impairment would be great—but are you able to provide the committee with a particular source or a document that gives evidence to that number of 50 per cent or around that?

Ms Krulin: Yes. In 2018 Human Rights Watch conducted a very extensive report. It looked at prisons around Australia and I think it interviewed—I might be incorrect here—about 300 current and ex-prisoners and the focus of those prison visits was in Queensland and in WA. They focused on those areas because of the regional spread of those states.

The number that they came up with there was at least 50 per cent. As part of our community legal centre requirements, we have to take a certain amount of information about each person when we set up a file. PLS is trying to go beyond what is expected there from a compliance perspective to understand exactly what type of disability it is. Those figures indicate that it is much higher.

Mr SMITH: We heard from the Queensland Nurses and Midwives' Union about nurses coming into correctional facilities for patients with more severe forms of cognitive impairments and cognitive disabilities. What does it look like in terms of other health workers who come into the prisons and provide any form of health work? Is it strictly limited more in terms of nurses, GPs and so forth?

Ms Krulin: No—all types, all visits, particularly psychosocial related visits. As I mentioned, the opportunity to have supervision in the community under parole and not just be released at the end of your time, which is a much better outcome for the community, for prisoners and for prison staff, is often dependent on being able to complete programs. Those programs are only offered in certain prisons. You need to be able to be transferred. There is often a waitlist, as there is. That also contains social supports. It could contain counselling services depending on the program.

Mr SMITH: Do you foresee that in future the Inspector of Detention Services may be able to play a role in terms of communicating with prisoners and yourself as a service and report back to parliament around matters of managing COVID-19 in prisons?

Ms Krulin: Honestly, I am not sure. I think it is a very important role. We are very excited to have seen a form of that passed recently. This is happening now, though. The lockdowns are happening now. Different centres have lockdowns as a measure as part of their management unit plans, because that is just what they do. This will allow that to continue in a fairly unsupervised way for significant periods of time for the next year. There are implications for someone who gets stuck in that cycle—who cannot complete the program, cannot get parole and cannot be released. That will have a direct impact, particularly on Aboriginal and Torres Strait Islander persons. Potentially it will also impact on their human rights such as cultural rights, rights to family, sorry business and attending funerals.

Mr SMITH: We have spoken about the mental health and disability side of things as well. Is there data on the number of prisoners within the system who have a higher risk of diseases—diabetes, respiratory issues—who are more susceptible to a possible COVID outbreak? Do we have that data?

Ms Krulin: I do not know that. I am not sure. That would perhaps be better put to Queensland Health, but I am not sure that they would have those numbers either. Certainly, we have had clients who have had significant injuries or conditions where medication was required and there was difficulty getting it, but we do not know.

Mr SMITH: Could that perhaps be a reason for the determination around wanting to be very careful about outbreaks of COVID-19 throughout prisons? What of the fact that there may well be a greater number of prisoners with higher respiratory issues, potential comorbidities and so forth? Is that perhaps a validation of the factors determining shutdowns?

Ms Krulin: If it is a validation, it is not one that has been made or offered. I think it would be difficult for that to hold water against certain other communities and cohorts such as persons in disability accommodation or in aged-care facilities who have similar comorbidities.

Mr ANDREW: How have the emergency measures impacted on the mental health and health generally of prisoners? Have suicide rates or death rates increased?

Ms Krulin: I apologise to the member. I do not have that data at the moment. I think it would be quite difficult, although the coroner who investigates suicides—several of them—may be able to assist. I would be happy to look into it a little bit if the member would like.

CHAIR: That is entirely up to you. We might conclude there. Thank you very much for your contribution.

Mr MOLHOEK: Is that a question on notice, Chair?

Mr ANDREW: That is a question on notice, I believe.

CHAIR: If you want to provide the data, I think the Mental Health Commission might be best placed for it.

Ms Krulin: I can let the member know that I can ask the questions of the relevant entities but may not be able to provide the answer.

CHAIR: Fair enough. Thank you very much again for your contribution.

WILLIAMS, Ms Karen, Principal Solicitor, Aged and Disability Advocacy Australia

CHAIR: Thank you very much for being here. Is Mr Rowe joining us today?

Ms Williams: Unfortunately, he is an apology today, but I have the benefit of his wisdom.

CHAIR: We do appreciate your submission and your regular contributions to the Health and Environment Committee. Thank you for being here. Would you like to make an opening statement?

Ms Williams: I would. Thank you very much for the welcome. We very much see this as part of our role to participate in these types of forums. I too would like to acknowledge the traditional owners of the land on which we meet today and pay my respects to elders past, present and emerging. Briefly, as you are aware, ADA is a not-for-profit, independent, community advocacy based organisation. We are coming up to our 30-year celebration of being able to support older people and people with a disability throughout Queensland. In particular, my role in ADA is I am the principal solicitor for ADA law. It is a recent program within ADA that specifically works with people with a disability and older people who may have decision-making disabilities in particular.

As you can see from the submission, overall we are quite supportive, but our concerns in relation to people with a disability and older people in Queensland are that there has been a disproportional effect on both sectors from the impact of COVID-19 itself and from measures taken to protect people from COVID-19. Recently, we were able to participate in a webinar with the deputy CHO in terms of people with a disability. The amount of fear that remains out there for people with a disability is quite palpable. People are fearful that they are being forgotten as we move away from the stronger attempts to safeguard from COVID. Older people have been impacted by the disproportional restrictions that often have been placed on them.

I also note that there has been a lot of work done in relation to loneliness and isolation. There is so much in terms of people being quite isolated in institutional living in aged-care settings. Whilst it is Commonwealth regulated, we acknowledge that people are still Queensland citizens and that there needs to be some type of balance struck in terms of where do we go. We often see disproportional measures where there is no recent or current outbreak. It is not linked to geography, but some providers seem to go over and above and not sort of meet the mark of getting that balanced impact.

In our submission we talk about people having access to lawyers and advocates. For example, we are still providing advocacy before the Mental Health Tribunal or the Queensland Civil and Administrative Tribunal. A lot of people we cannot work with over the phone. We have to have face-to-face services because of hearing impairments or other disability requirements. It is very difficult to provide that basic level of support.

CHAIR: Thank you, Ms Williams. We all can remember the images of older people in institutions right around the world during the height of the pandemic and the horrible situations for families. I understand in Queensland people could go into those facilities if they were terminally unwell. Provisions for that were made in the old bill. I should not know this number off the top of my head, but I do. There are 459 privately-run facilities and 16 state-run facilities in this state. I know that because of the work of this committee in the aged-care sector. You mentioned the implications of the powers for persons residing and/or temporarily staying in those residential aged-care facilities. You go on to strongly suggest that these powers be reviewed and amended to include appropriate safeguards against over-reliance and inappropriate or disproportionate restrictions being placed on your members in those residential aged-care facilities. Do you want to expand on that a little bit?

Ms Williams: Yes. The difficulty we have had in supporting our clients is that it is very much a Swiss cheese approach. There is no blanket approach out there. You cannot say that we will provide this, that or whatever information to the facility and then we will have access. It is very much case by case. When there is a blanket refusal on access and it goes on and on, we get very jaundiced about what might be the reason for that difficulty in access. If there is an actual outbreak in the facility, we do not have a problem with that. We do not have a problem with sharing our information about vaccination status, doing RAT tests and temperature checks and all the rest of it.

For the clients that we can talk to over the phone, they can be quite distressed about why they cannot progress their issue of concern with us or with anyone else for that matter. Some people are not visited by anyone. They do not have a support network as such. They might be seeking assistance to reach out to people. They might use our organisations to try to do that or to discuss their decision-making arrangements more broadly. It is very hard to describe that level of isolation. Even though that is my work environment, I still find it difficult to try to picture myself in that level of isolation. We can understand it for an acute period of time, but it is very difficult to do so once it goes into weeks and months where people are extraordinarily isolated.

Ms PEASE: Thank you very much for coming in and thank you for the great service that you provide. My electorate is full of very elderly people. I know that during COVID they were very supportive of the restrictions that were in and felt safe because of that. Was that evident within the cohort of your membership?

Ms Williams: Yes, there is certainly a mixture. That was the recent response that Mr Rowe reported to me about the webinar. They are feeling safe and then there is a need to off ramp that as we step-down and out—

Ms PEASE: Has there been any negativity to this step-down approach? Have you heard from any of your members around that?

Ms Williams: Only from the recent meeting that I was not party to that Mr Rowe was keen that I mention. There was fearfulness of moving out of that safety net and not feeling that anyone had their backs. This was particularly for people living with a disability. It is that need to tailor for the various cohorts when safety measures are put in place. It is not just about institutional living but also home care workers coming in and out of the home. Workers are going to multiple sites and might be working for multiple agencies. It is a different cohort and some leaning into needs to happen to take their situation into account. There is a gratefulness about that safety net and then as it steps down there is fearfulness for some.

Ms PEASE: You have quite a diverse membership. You have people who are residents in residential aged-care and disability homes and then you have people who live in their own homes and, as you say, have home care visitors coming through. I am interested in residential aged-care facilities. I acknowledge how difficult it was for the residents and also acknowledge the added workload put on the staff. As you said, unless you have lived through this you would have no understanding of what it is like. I make the comment that it was terribly hard for people. I have had friends who have taken their family members out and had them at home because they could not bear to not see their family members.

Ms Williams: I have an appreciation of the enormity of those sorts of decisions.

Ms PEASE: It was very hard and came at a huge personal cost for some people but a broader benefit to our whole society. These measures were put in place to protect our society. I thank them and acknowledge them for that contribution.

Mr MOLHOEK: Ms Williams, thank you for joining us today and for your submission. In your submission you talk about the need for exemptions. You particularly touch on advisers and advocacy but also end-of-life visitors. Can you expand on why you see the need for that? Can you give us some examples of cases that would perhaps fit those exemptions and why they need to be in place?

Ms Williams: One example is tribunal matters that are ongoing in, say, the mental health tribunal. There were people who were in health facilities or SIL housing who had been going really well with their recovery and wanted to tell their positive story to the tribunal. It was very difficult to get to them. It was very difficult for them to understand that they were caught in terms of their conditions lessening and their trajectory of moving out of hospital. They might have been having two days in hospital and five days out. There was a big interruption in their recovery journey which was their focus. It was very difficult for them to wrap their heads around the fact that the interruption and the reason they could not move forward was not a reflection on them. That is how they felt. They would think: 'What else do I have to do?' Particularly in the early days it took a while.

It was also very difficult to access people and provide that support for them with the tribunal in a face-to-face way. Whilst hearings could go online, most of our clients do not have the technology—a mobile phone or something—to participate in hearings. They might have had an application into QCAT for some months and then they cannot address that. Clients were unable to access psychology services and things like that face-to-face to address their distress.

Mr MOLHOEK: In your submission you talk about end-of-life visitors. Are you suggesting that there should be exemptions for the family priest and family members to be with their family at the end of life?

Ms Williams: Everyone's circumstances are different and culturally different. For a lot of our clients English is their second language. It is very difficult to prescribe who might be regarded as an end-of-life visitor. It could be a religious person or someone of cultural significance or family of choice. Often what happens under this sort of stress is people look to the substitute decision framework—the attorney, guardian or whoever—and maybe not look more broadly as to who they might want around them in an end-of-life situation. We get a lot of calls from third parties who are family members or friends and feel quite excluded from that process. There might be other family dynamics at play and it is all too hard to sort out at a stressful time. It is hard to access the person to know who they want rather than who is on the formal piece of paper.

Mr SMITH: Thank you for being here today and for your advocacy. At page 2 of your submission you talk about the fact that there is little clarity or comfort in the bill around the need for the provision of exemptions relating to individuals' continued access to medical and other healthcare appointments. Were there any examples where people came to you advocating that they were denied medical treatment or medical appointments by residential care providers? Did any evidence of that come up during the last few years?

Ms Williams: I cannot recall that specific example. I am happy to check that. Where I am coming from is the legal perspective. Often we are trying to support a person to get specific reports rather than treatment. I want you to understand that I am not talking about treatment, apart from the psychology example I mentioned. Often people are wanting a review or to get reassessed. People find themselves in aged care either short term or long term and they feel that their health situation has changed. They have had some resolution from their stroke or whatever and they need a reassessment as to what might be their next step. It is extraordinarily difficult to get that reassessment of their situation which has to done by a health professional.

CHAIR: Are you happy with that response?

Mr SMITH: Yes, I am.

CHAIR: There being no further questions, thank you very much, Ms Williams. Please pass on our regards to Mr Rowe.

Ms Williams: I will do.

CHAIR: Thank you very much for your submission and contribution today. We will take a break and the public hearing will resume at 1.20 pm.

Proceedings suspended from 12.39 pm to 1.23 pm.

COPE, Mr Michael, President, Queensland Council for Civil Liberties

CHAIR: I now welcome the President of the Queensland Council for Civil Liberties, Mr Michael Cope. Thank you for being here and thank you for your submission. Would you like to make an opening statement before we go to questions?

Mr Cope: Yes. On behalf of the council, I thank the committee for the opportunity to appear before it today. The council's position is that the COVID emergency that justified some emergency powers being given to the Chief Health Officer is over. These powers need to be ended before they become permanent.

This position is based on three propositions: one, the COVID virus is now circulating widely in the community; two, we now have highly effective vaccines and treatment. In that regard I note that on 19 August the Therapeutic Goods Administration granted the manufacturer of the COVID treatment Sabizabulin permission to apply for provisional registration of that drug. This is an important step because that is an antiviral treatment which can be used more than five days after infection which is a limitation on the current treatments. According to the manufacturer of that drug, it reduced fatality by 55 per cent in those suffering from severe COVID, so much so that the trial was cancelled for effectiveness so that they could give it to the people taking placebos.

Three, the government refuses to give any indication as to when the COVID emergency powers will cease to be needed. The virus is going to continue to circulate in the community forever so far as we know. We cannot see how the current situation is going to be any different in 12 months time absent a variant which smashes through all the existing immunity. I note the public response by the department does not, whilst acknowledging this comment, say anything about it. Our position is that taken by a number of European countries, serious European countries, as well as by a number of states in the United States including places like Hawaii, which is controlled by the Democrats.

I have just come back from spending a week in Cyprus where there was a mandate requiring the wearing of masks in indoor public places. In my whole time there I counted less than 20 people complying with that rule. Whilst I expect that Queenslanders, like all Australians, despite their self-image as anti-authoritarian, are more likely to comply with this rule than the Cypriots, I expect that a lot of people will not comply with this rule. What is the government going to do? Is it going to deploy the police to prosecute people en masse or to allow the law to be made look like a fool?

Apart from that I wish to make a couple of additional specific comments. Firstly, a point that should have been made in the submission is that we do not support sections 142N and 142O. Why should health inspectors be able to enter premises without a warrant to deal with this virus which is circulating everywhere? In addition, we endorse the comments of the Human Rights Commission on those provisions. Finally, in relation to the Corrective Services provisions, we endorse the comments of the Prisoners' Legal Service.

CHAIR: Thank you, Mr Cope. Your comment about the percentage of people you saw not wearing masks in Cyprus was interesting. As a regional member, I travel quite a bit, and only yesterday there were quite a number of people who were self-managing this, as the Chief Health Officer said this morning. They were still wearing masks on the plane even though it is not mandated anymore. It is a different view from what you have just said. If people are coughing around you—

Mr Cope: Of course we say that people should be entitled to wear masks. I continue to wear masks on public transport when it is granted but we just do not think it should be a rule. People should be entitled to take their own decisions about that. If that is what they do, that is fine. They should not be criticised for it, as some people are.

CHAIR: Do you see aspects of this bill, such as the winding back of broader powers like border closures, as a good thing?

Mr Cope: As our submission says, there are vast improvements in this bill over the enormously wide powers that the Chief Health Officer had. But, as we have said on a number of occasions, our concern is that all emergency powers should come to an end as soon as possible. I still do not understand what the criteria is by which the government will say no more powers are needed. It is not advanced anywhere that I can see. You have to be concerned that this is just going to be rolled over because the virus is not going anywhere. It is not disappearing. It is likely to be here forever. Are we going to continue to have these things forever? We would have more confidence if the government actually stated what the rules are. The government did state a rule at the end of 2021 which was when the vaccine was made available to every person who wanted one. We are past that now. Since then I have not heard any definitive statement of any rule by which the government will decide that no more powers are required.

CHAIR: Did you catch any of the Chief Health Officer's evidence this morning?

Mr Cope: No, sorry. I was working.

CHAIR: I welcome you to read *Hansard* because he talked about the provisions in this bill being 'just in case' for the next 12 months—no-one has a crystal ball—should another variant happen. I welcome you to read that.

Mr MOLHOEK: It is probably a big leap to just say, 'No more powers.' In terms of civil liberties, as I understand it, the case that you are putting is that everyone should be free to make their own choice. What would you contend is fair in terms of the broader general public when perhaps some people are making bad choices that impact on the freedoms of others?

Mr Cope: First of all, there are vaccines which people can take that are highly effective at preventing illness. There are other alternative treatments, as I have mentioned. People are entitled to wear masks to protect themselves. This is an infectious virus which is everywhere in the community now. In a sense that it is everywhere in the community now it is no more different than the flu circulating in the community. I am not suggesting that COVID is the same as the flu. The debate about that confuses me. Let's presume for a moment that it is worse than the flu. Still the flu is everywhere. There are all sorts of viruses floating around the community. For example, lots of people die in aged-care homes from the common cold.

The community has, in large part, done what it is obliged to do to protect other people. We have developed extremely effective vaccines which people can take. They can take other treatments. Other treatments are coming down the track. If you read the reviews, they suggest that highly effective antivirals are being made by all these people who are spending lots of money doing that. To the extent that you do not gain protection from those things, you can continue to wear a mask and take other steps.

I accept that at the end of the day these things are judgement calls about the relationship between individual liberty and how individual rights interact. We have now got to a point which I have just described where you have all of those treatments and you have all of those methodologies. The community has been through a long period of lockdown and has not been able to go anywhere. All of those things were designed to achieve this result. Do not forget that. That was the purpose of them. The purpose of them was to get us to this position. Now we want to carry them on, despite the fact that we have now reached the position which was the articulated aim of them.

My answer to that is that we have achieved the position where, through the magic and brilliance of science and through great sacrifice for two years, we have achieved the result where there is an appropriate balance between the various interests of various people in the community and that people can, as I say, protect themselves still by wearing a mask if that is what they want to do.

Mr ANDREW: I am so sorry I could not be there to see you in person, Mr Cope, and hear your refreshing view on the whole situation. It is important not to get too involved in 'group think'. I think you have hit the nail on the head there. Just quickly, with regard to the unelected officials I spoke about earlier and the way they would be running the show rather than coming back into the parliament or Legislative Assembly over the last day on some of this, what are your thoughts on that? Have we gone far enough in this legislation to look at mandates and rescinding or repealing some of these mandates so that people who have had COVID can go back to work and form a helpful part of society if they can demonstrate they have antibodies?

Mr Cope: There are a couple of points in there. I should probably have taken notes. The effect of these laws will be to end the current mandates because all of those will expire 31 October. That is why we say it is a major step forward, so I do not see your concern about that. In terms of continuing rules about vaccination requirements and whether infection should be treated as a substitute, as I say, our position is that, whatever arguments you may have been able to make about vaccine mandates 18 months ago, they do not make any sense to us anymore and there should not be any more of them. As to the question of substitute immunity, that really is a highly scientific question and I will leave that to the Chief Health Officer to decide. I think there was a third point.

CHAIR: I think that was it. I will let the member for Mirani come back if we have a supplementary.

Ms PEASE: Thank you very much for coming in, Mr Cope. I appreciate your submission. I just want to elaborate on what the member for Southport was asking with regard to the new legislation. If you are not comfortable with what is coming in at this particular point in time with the sunset clause in October 2023, what do you think would be appropriate in its place?

Mr Cope: Our answer is that there should be nothing. But if there is to be something, it should be subject to the further things we mention in our submission—points which we have been making on a number of occasions—that these directions should be made by the minister and that people who are subject to detention should be subject to a right of review. The parliament should confirm that you can challenge the decision to issue these directions under the Human Rights Act and, given our view that we do not think these things are necessary, people who lose money as a result of them should be compensated for it.

Ms PEASE: With regard to the health directives that are in place where the Chief Health Officer has the capacity to make those directions, you have made it very clear that you feel that is an overstepping of the CHO's position.

Mr Cope: Our position was that all the Chief Health Officer's powers should have gone the last time they were extended. Our position was that they should have gone on 31 December last year.

Ms PEASE: The Chief Health Officer today spoke about the big Omicron wave that came through which peaked in July when we had to respond to a completely new variant. At this particular point in time, as the Chief Health Officer has said, we do not know what variants might be out there. Does your organisation know what is coming?

Mr Cope: No. As has been pointed out in the previous submission, if you have a variant which is demonstrated to get around the vaccines then that will justify some return to some sort of emergency powers. Our position is that the government is required to justify that at the time. If that is the situation then more than likely the current powers would not be sufficient. Emergency powers need to be justified on every occasion they are used. If the government says, 'There is another variant'—and there are so many out there and lots of them are said to be the next devil variant, and they are not so far, but of course I anticipate possibly there might be such a thing—then the government needs to turn up and say in public, 'Here is the scientific evidence which says that this will escape the immunity which is generated by vaccines.'

There is a big debate about whether neutralising antibodies are a clear indication of immunity as opposed to T cells. You can read Paul Offit, who is an adviser to the federal Food and Drug Administration in the United States to learn more about that. If the government says that is the position then they need to stand up and say that. They need to demonstrate that, then they need to say why the particular powers they want are justified, and they pass it through the parliament.

Ms PEASE: I guess that is one of the reasons why there is a statement of justification with the legislation. One of the points of having these three steps that only the Chief Health Officer can introduce is that it can be done in a speedy and appropriate fashion for serious reasons. What is the likely impact to the community of delaying that by having to reintroduce legislation into the House and having a debate in parliament?

Mr Cope: In an emergency situation parliament should be able to attend to these matters in an urgent fashion. In 2020 the whole place was closed down, in our view for entirely unjustified reasons because it all could have been done on Zoom, so I do not accept parliament cannot act speedily if necessary. We are not facing that situation at the moment. If you have a variant which is of that nature, sadly for people outside the developed world—or whatever term you want to use—it is going to be clear like Delta was in India and the current Omicron was in South Africa. There will be a lot of evidence about what is happening. The whole premise of your question assumes that the parliament can just continue to roll on this emergency forever, and it cannot. When does it finish? My question to you is: what is your criteria as to when it finishes?

Ms PEASE: We are asking you questions.

Mr Cope: I know, but you are the committee. You should be asking the government that question, with all due respect.

Ms PEASE: Have you read the bill to see what it says?

Mr Cope: Yes, I have read the bill.

Ms PEASE: It expires. There is a twilight clause in there for 2023.

Mr Cope: Yes, but why shouldn't it expire now?

Ms PEASE: With respect to those comments you made about how quickly those countries were able to respond and act, we also had to respond and act really quickly here in Australia. Much of the reason why we were able to respond and act so quickly was due to the health directives that were put in place by the CHO. With the removal of any of those—again, I put my question to you—how many people are going to die from something that we do not know which may or may not come?

Mr ANDREW: That is seeking an opinion, Chair.

Mr Cope: First of all, the Chief Health Officer did not have those powers until they were introduced by this parliament.

CHAIR: I will allow a bit of latitude.

Mr Cope: Those powers were not in the Public Health Act before whenever they were introduced in 2020, so the parliament did react and did produce powers. That is what happened last time and surely it could happen again. As I say, it is for the parliament to justify having an emergency. It is not for the public to justify it: it is for the parliament—the government.

Mr SMITH: Mr Cope, thank you for coming in. How does COVID-19 formulate, mutate and infect the human body?

Mr Cope: I am not a medical practitioner.

Mr SMITH: To enter this place there is a dress code required. Is that an attack on civil liberties?

CHAIR: That is really not relevant, member.

Mr Cope: No, it is not.

CHAIR: I think we will conclude there. Thank you, Mr Cope, for coming in and for your submission and contribution today. There were no questions taken on notice. That concludes this hearing. Thanks to everyone who has participated today. Thank you to our Hansard reporters. A transcript of these proceedings will be available on the committee's web page in due course. I declare this public hearing closed.

The committee adjourned at 1.43 pm.