HEALTH, ENVIRONMENT AND INNOVATION COMMITTEE

Members present:
Mr R Molhoek MP—Chair
Ms SL Bolton MP
Ms K-A Dooley MP
Mr JP Kelly MP
Mr DJL Lee MP
Dr BF O'Shea MP

Staff present:
Dr J Rutherford—Committee Secretary
Miss A Bonenfant—Assistant Committee Secretary

PUBLIC BRIEFING—INQUIRY INTO THE HEALTH LEGISLATION AMENDMENT BILL 2025

TRANSCRIPT OF PROCEEDINGS

Monday, 31 March 2025

Brisbane

MONDAY, 31 MARCH 2025

The committee met at 11.40 am.

CHAIR: Good morning. I declare open this public briefing for the committee's inquiry into the Health Legislation Amendment Bill 2025. My name is Robert Molhoek. I am the member for Southport and chair of the committee. I acknowledge the Aboriginal people and the Torres Strait Islander people of this state and their elders past, present and emerging. With me here today are Mr Joe Kelly, the member for Greenslopes and deputy chair; Mr David Lee, the member for Hervey Bay; Ms Kerri-Anne Dooley, the member for Redcliffe; Dr Barbara O'Shea, the member for South Brisbane; and hopefully joining us shortly will be Ms Sandy Bolton, the member for Noosa.

This briefing 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 or affirmation, but I reminded witness that intentionally misleading the committee is a serious offence. I also remind members of the public that they may be excluded from the briefing at the discretion of the committee. I remind committee members that officers are here to provide factual or technical information. Any questions seeking an opinion about policy should be directed to the minister or left to debate on the floor of the House.

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BRYANT, Ms Peta, Deputy Director-General, Strategy, Policy and Reform Division, Queensland Health

LIDDY, Mr James, Manager, Legislative Policy Unit, Queensland Health

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

WEST, Mr Mark, Executive Director, Preventive Health Unit, Queensland Health

CHAIR: Welcome. I invite you to brief the committee, after which committee members will have some questions.

Ms Bryant: Good morning, Chair and committee members. Thank you for the opportunity to brief you on the Health Legislation Amendment Bill 2025. My name is Peta Bryant. I am the Deputy Director-General of the Strategy, Policy and Reform Division. Today I have with me my Queensland Health colleague Mark West, the Executive Director in our prevention strategy branch in the department. From within my system policy branch I have experts in legislative policy: Mr Karson Mahler, who is a director in our Legislative Policy Unit, and Mr James Liddy, a manager in our Legislative Policy Unit.

Before I start talking about the reforms in the proposed amendments, I acknowledge the traditional owners of the lands upon which we are meeting and pay my respects to elders past, present and emerging. I also extend those respects to any First Nations people we have with us here today.

Queensland Health is committed to improving our performance and governance across the system. As part of that, this legislation amendment proposes changes to improve effective enforcement across public health measures and also to make changes around the extent to which clinician voices are represented on our hospital and health boards. The bill addresses two key areas, which is really around ensuring stronger frontline representation on our hospital and health boards and enhancing those enforcement powers to curb the illegal supply of vaping products. The reforms reflect the need for practical and targeted legislative changes to support both our health system and the broader community. I will talk about the bill in broad terms and then go a little deeper on each of the two proposed reforms.

You might be aware that the charter letter for the Minister for Health and Ambulance Services includes a commitment to amending the legislation to ensure that hospital and health boards include at least one frontline staff member who is working in a local health facility. The bill implements that commitment by amending the Hospital and Health Boards Act 2011 to ensure that clinicians who are working directly in our hospital and health services are represented on those boards. The change recognises the invaluable expertise of our health workforce and ensures that those delivering care on the ground have a stronger voice in shaping the way that services are delivered and also the performance of our hospital and health services.

The bill also makes important amendments to the Tobacco and Other Smoking Products Act 1998, or TOSPA as it is commonly referred to, to bolster Queensland Health's enforcement powers for vaping goods. These reforms will improve the ability of enforcement officers in our public health units to forfeit and destroy illegal vaping products and to do so more efficiently to ensure that those engaging in illicit trade can face greater financial consequences.

In terms of the amendments to the Hospital and Health Boards Act 2011, the amendments proposed in the bill require that each of the 16 hospital and health boards have at least one board member who is currently working as a frontline clinician in a public hospital or facility. The bill requires that the clinician has been working in that local hospital and health service for at least two years and that they are delivering, at a minimum, eight hours of direct patient care each week. The clinician must be a registered health practitioner under the Health Practitioner Regulation National Law. That means that they can be a doctor, a nurse, a midwife or an allied health practitioner. This change will ensure that there is a person on the board with not only clinical experience but also local experience of working in the hospital and health service that the hospital and health board controls. This will bring an invaluable and really unique perspective to the board and to the decision-making of that board, particularly in an environment where we are looking at ensuring that clinicians can represent what 'good' looks like not only from a clinician perspective within the hospital and health service but also from the perspective of the local community.

If the bill is passed, the new requirements will come into effect on 1 April 2026. This aligns with a major round of recruitment that we are undertaking for the hospital and health boards. That major round of recruitment will be closed out by 31 March so these changes would be enacted with those new appointments. This timeframe allows for the critical roles to be promoted and advertised across our health services from the middle of 2025 and will ensure that we find the right people for these important roles.

In looking at the changes to the Tobacco and Other Smoking Products Act 1998, what we are proposing really aims to strengthen Queensland Health's enforcement against illegal vaping goods. Queensland, like many jurisdictions across Australia, is facing a significant challenge in tackling the commercial supply of vaping products. The prevalence of vaping, particularly among young people, is a public health concern. The evidence shows that vaping products can cause respiratory conditions, can contribute to cardiovascular illness and can also contribute to mental health concerns such as anxiety. Despite these known harms, illegal vape retailers continue to operate across Queensland, selling products that are unregulated and falsely marketed as safe alternatives to smoking.

Queensland Health enforcement officers have been ramping up their efforts. Since 1 January 2025, more than 81,000 vapes have been seized. This is a testament to the good work that these enforcement officers are doing and the way they are already lifting and working well to protect our community. However, enforcement is being significantly hampered by the logistical challenges of storing and destroying these products. Currently, Queensland Health is required to store these vaping products for at least eight weeks before they can be forfeited and destroyed. This is to accommodate the legislated show cause process and help manage the risk of compensation claims. Those compensation claims can result if a forfeiture decision is overturned or a court ordered stay delays the destruction of those vaping goods.

Vapes contain hazardous chemicals. They contain lithium ion batteries and toxic liquids which means that they require really strict storage conditions. They require units that are ventilated and protect against overheating because of the risk of potential explosions of the batteries in those devices. Those specialised units that are ventilated and protect against possible explosion come at a significant cost. They can cost up to $65,000 per unit. With more vapes being seized, storage facilities are reaching capacity. This is putting pressure on Queensland Health's ability to effectively conduct enforcement and is at a significant cost.

The destruction of vapes is not only costly but also complex. Vapes cannot be discarded like regular waste; they must be dismantled, with plastics, batteries and toxic liquids requiring separate handling. Improper disposal risks personal injury and also environmental contamination, which

contribute further to the cost for the state. To address these challenges, the bill provides for the immediate forfeiture of seized vaping goods. This will mean that illegal vapes could be destroyed as soon as they are forfeited. The bill will eliminate the need for prolonged storage and will ensure that enforcement officers can continue to remove these products from the community. This change is a necessary step to ensure that enforcement remains effective, efficient and sustainable.

Beyond enforcement, the bill also introduces a new court ordered cost-recovery provision. This will ensure that those who profit from the sale of illegal products such as vapes, including illicit tobacco and ice pipes, will be held financially responsible for their actions. This provision provides a clear basis for courts to order convicted offenders to pay the costs associated with the enforcement of offences related to these products. The costs could include storage, dismantling and destruction as well as the expenses of investigation and prosecution.

Queensland Health's enforcement teams are working tirelessly to combat the illegal vape trade, but stronger measures are needed to address the ongoing challenges in enforcement and compliance. The widespread availability of illegal vapes remains a significant concern and this bill ensures Queensland Health has the tools it needs to support sustained action against noncompliant retailers. The amendments proposed will strengthen the state's ability to remove these harmful products from the community. Thank you, Chair and committee members, for the opportunity to brief you on the Health Legislation Amendment Bill 2025. We would be happy to take any questions.

CHAIR: I might kick off with a question that is probably more out of curiosity. Can you perhaps go into a little bit of detail about the cost of disposal? You mentioned that vapes need to be disassembled. Could you elaborate on how and where that is done and what the costs are?

Mr West: I am happy to answer that. We have sought prices from providers who can destroy these products. We have a standard offer arrangement with several companies. It is a little bit tricky because we are very conscious of the fact that they are hazardous products that are made of plastic and we are interested in recycling as many components as possible. There are providers on our standard offer arrangement that have a set price. I can give you the details of the price on notice because I do not have them with me at the moment.

The price was negotiated. We went to the market to find providers to do this. We were clear in our message that we wanted the products to be disassembled. We want the battery and any liquid that is left in it taken out, as well as all the plastics, and there are facilities that can destroy those products.

CHAIR: Thank you.

Mr J KELLY: The changes to the Hospital and Health Boards Act seem to be predicated on a statement made by the government around a desire to put doctors, nurses and clinical staff back in charge of hospitals. Can you provide any factual data that doctors, nurses and other clinicians are not in charge of hospitals?

Ms Bryant: There are clinicians already on our health and hospital boards. The real change this will make will be including clinicians who are delivering direct patient care and who are working in that hospital and health service that the board controls. We already have clinicians on some of the boards to comply with the current act. Those clinicians may be working in a neighbouring HHS, in the private sector or in primary health care in the hospital and health service. These proposed amendments will complement that by having a clinician from the HHS that the board controls contributing to decision-making, particularly around improvements to service delivery and to the retention and recruitment of the workforce, for example.

Mr J KELLY: Going back to that statement around doctors and nurses not being in charge of hospitals, in terms of the 16 HHSs, can you advise how many of the CEOs have a clinical background?

Ms Bryant: I would have to take that on notice. We do have a number of CEs who come from a clinical background. In terms of the boards, we also have some chairs or deputy chairs who have a clinician background.

Mr J KELLY: Could you take that on notice and provide the details of every single board and every single CEO's clinical background, if they have them?

Ms Bryant: Can I just clarify: is it the CEOs you want to understand or just the boards?

Mr J KELLY: Both.

Ms Bryant: Okay.

Mr J KELLY: In each of these HHSs, there would be a medical director? Is there a medical director in every HHS?

Ms Bryant: In every hospital and health service or on the board?

Mr J KELLY: No, is there a position of medical director for each HHS?

Ms Bryant: There is typically a role for a medical director in the hospital and health services.

Mr J KELLY: Are they currently all filled?

Ms Bryant: I would have to take that on notice.

Mr J KELLY: Is there a nursing director or an executive director of nursing for every HHS?

Ms Bryant: There is typically a role for a director of nursing.

Mr J KELLY: Is there a clinical lead for allied health for each HHS?

CHAIR: Member, I think we are straying from the terms of the bill.

Mr J KELLY: Chair, with respect, this bill is about putting nurses and doctors in charge of HHSs. I am trying to establish what the current scenario is that we are trying to address. Is there an allied health lead for every HHS in terms of leading allied health professionals within an HHS?

Ms Bryant: I would also have to take that on notice. In playing that back to you, you would like information on the clinician background for each of the CEs of the hospital and health services and the chairs of the hospital and health service boards and also whether there is a director of medical services, a director of nursing and a director of allied health in each of the HHSs?

Mr J KELLY: Correct. The bill proposes to take a frontline clinician and put them into the board environment. Have you taken any advice from, say, the Australian Institute of Company Directors or Crown Law about the appropriateness of somebody at that level being involved in a board and how they will handle conflicts of interest?

Ms Bryant: Can I clarify: is the question about advice around whether clinicians can fulfil board membership roles or whether they can manage conflicts of interest?

Mr J KELLY: Both.

Ms Bryant: We have consulted on the proposed amendments and consulted with the chairs of the boards. A number of them have talked to me about how they have some ideas around who they might put into such roles and how they would like to elevate the voice of clinicians within the hospital and health service. I have also received feedback around the implementation timeframes.

We are being very clear that we have a unique opportunity to promote this opportunity of being a board member to clinicians who have experience in those capabilities that are outlined in the act currently. They might be clinicians who have experience in financial management, research, teaching and training or human resource management. They might also have experience in broader governance roles and systems management, which are also captured in the act as key capabilities. We have done that consultation around the proposed amendments.

In terms of conflicts of interest, we already have existing strategies for managing conflicts of interest. The Queensland Integrity Commissioner is often consulted around identifying conflicts of interest and developing strategies to manage or resolve those conflicts of interest. An example of that would be: if we went through the expression-of-interest process and a senior medical officer who was an oncologist was identified as a preferred candidate for a board, that board member would have to abstain from any decisions about the cancer services or oncology. Similarly, they would abstain from receiving board papers relating to those types of decisions. That might be an approach taken to manage that conflict of interest where a local clinician is on a board. That is common practice already—managing those conflicts of interest, developing a conflict-of-interest management plan and submitting that through to the minister for approval.

Mr J KELLY: If a board has, say, a nurse on there, will medical voices be heard, will allied health voices be heard, will pathology voices be heard?

Ms Bryant: I imagine so because—

Mr J KELLY: Or should we have one of each of those on the board as well?

Ms Bryant: That is not proposed in the amendments.

Mr J KELLY: Why not, if this is about putting nurses and doctors back in charge?

Ms Bryant: The amendments proposed align with the commitment, member for Greenslopes.

CHAIR: You are asking for an opinion. That is probably a question you should be directing to the minister or to the House.

Mr J KELLY: This is about putting nurses and doctors back in charge of the health system. In relation to issues that clinicians want to talk about—pill testing, hormone treatment and fluoridation are all things that clinicians have said they want dealt with—is this actually going to mean that clinicians will be listened to?

CHAIR: Member, I think we are straying from the overall intent of the bill.

Mr J KELLY: The intent of the bill is to put nurses and doctors back in charge of health services. When they say things the government does not like, it seems that the government does not listen to them. How will this ensure that if an uncomfortable truth needs to be spoken at the HHS level it will be heard?

CHAIR: I am not aware of any uncomfortable truths.

Mr J KELLY: My question was to Ms Bryant.

Ms Bryant: Member for Greenslopes, the boards already have processes for ensuring that members on their boards are heard around a full range of issues. In talking about uncomfortable issues or making tough decisions as a board, I imagine that they will use the same strategies. The chairs will engage with each of their members to ensure that there is no one voice louder than the others. They are all there to represent unique perspectives and to fulfil the functions and skills that are outlined in the act.

Mr LEE: Following up on the chair's earlier question in relation to disposal costs, you gave an indication about engagement with contractors moving forward. Do you have any information on disposal costs to date given that you talked about eight weeks of storage in air-conditioned, ventilated shipping containers? Have there been any costs incurred in disposal to date?

Mr West: There are two concepts there: storage—and secure storage, because these are illicit products—and destruction. At the moment, our enforcement officers undertake enforcement action at a shop and then seize the goods so we get them out of circulation. We all have the powers to do that—which is great. Then we need to process, sort, count, collect and do all those sorts of things, because it is evidence of an illicit activity.

The cost of storage to date is a little hard to calculate, to be honest, because we have 16 hospital and health services. They have all implemented different arrangements for their storage at the moment. My view is that it is not a large amount of money. They try to process things as quickly as possible but, as was mentioned earlier, we do have capacity issues at the moment. We want to keep enforcing; therefore, we do need some storage. The proposals in the amendment bill are around reducing the need to hold on to the products for eight weeks. By common sense, our costs will be less in future because we can forfeit them quicker.

The destruction costs will continue because we want to destroy these items. They are illicit tobacco items. We want them out of circulation. We do not want children vaping. The state will continue to incur a cost for destruction. Ultimately, for public health that is a good thing. It is a cost that we wear at the moment. Again—I do not have the numbers off the top of my head—it costs money to destroy things such as waste but the costs are not great.

CHAIR: Can I suggest as a question on notice that we get some feedback as to what has been spent?

Mr West: I am happy to.

Mr LEE: I understand the intent around anti-tobacco and vaping. It is certainly a big problem in many communities, but there is a basic micro-economic principle of supply and demand. It is clear what the mischief is in terms of what we are trying to achieve here with the legislation. I am aware of many in my community who potentially source cheaper tobacco products who are challenged, who are socially or economically disadvantaged. One of the policy implications of this will be to address the illegal tobacco market. Given the high cost of those legitimate operators with taxes on tobacco, what opportunities are there for us to, from a preventive health point of view, address the implications of this legislation?

Mr West: The question is a bit broader than what is in the bill, but I am happy to provide policy comment on the significant challenge of illicit tobacco and vaping at the moment. The challenge with illicit tobacco is that it is cheap tobacco which means that people keep smoking or decide not to quit smoking—which is what we want—because the smokes are cheaper. My public health concern about illicit tobacco is that it is just tobacco. It is a type of smoking that we are trying to reduce. We have had a long record over two decades or longer in which we have halved the smoking rate in Queensland. The latest Chief Health Officer's report shows that diseases such as COPD and

coronary heart disease have reduced for Queenslanders, and a lot of that can be directly attributed to the fact that fewer people smoke now. Our absolute main public health goal is to continue to reduce the smoking rate.

You are correct: it is a supply and demand issue. We are doing our very best to reduce demand, to remind people of the harmful dangers of smoking and vaping, especially young people who are trying vaping. We know that vaping leads to regular smoking. Vaping is absolutely a gateway drug to smoking. Big tobacco companies own vaping companies. They run the vaping business now internationally. They are interested in future smokers. It is a very wicked problem and we are trying to tackle it on multiple fronts. There is a role for the Australian government. They ban advertising on packs. They put the excise on tobacco products. The excise is a Commonwealth issue; it is not a state government issue. We have smoke-free environments. We ban selling smokes to children. We also follow through the federal laws around vaping. All states and territories are working very closely with the Commonwealth in trying to tackle both illicit tobacco and vaping.

Ms BOLTON: Going back to what you were just talking about from a public health aspect, when vaping first arrived and concerns were raised, why has there been a lag instead of at the beginning just banning it?

Mr West: Queensland was actually the first jurisdiction to take action on e-cigarettes. We were the first state to mobilise a minister to support change for public health and amend legislation—and all of this takes a little while. We included treating e-cigarettes the same as tobacco products. We used our own legislation in Queensland to say—because people were starting to use vapes in pubs and clubs or in their workplace or on a bus—'We can control this.' We put in place legislative reforms that treated the use of e-cigarettes like smoking. The Queensland government took action first in that space, led by the then chief health officer, Dr Jeannette Young.

Hindsight is an interesting thing. The biggest increase in vaping happened during COVID. The public health community and every chief health officer were focused on the immediacy of COVID. Looking back now, things could have been done a couple of years earlier—that is my policy view—but we did mobilise before COVID to treat e-cigarettes the same as tobacco. The Commonwealth government support for reform in this space has been world-leading. It is very good. If you are an adult, you can now only get a particular type of vape, at a particular strength, with no flavouring, in a very ugly box from a chemist. If you are a child, you have to get a script. That is the national approach and Queensland mirrors that totally.

We are closely monitoring the use of vapes, especially by young people. We anticipate that that will level out very soon. We do really hope—because we are doing a lot of work—that that will start coming down. In terms of a public health response, we are all coordinated and we are all driving reform in this space.

Ms BOLTON: With respect to the fact that clinicians as board members are not able to serve as chair or deputy chair because of concerns around potential conflicts of interest, why is there one set of standards for the chair or deputy chair versus sitting on the board?

Ms Bryant: The chair and deputy chair have unique responsibilities in probably two key ways. One is around them having a casting vote on any decisions of the board. The other is that it is the chair that signs the service-level agreement with the Department of Health. That is quite a big responsibility, obviously, around the budget and linking funding to service delivery for that HHS and its activity targets. A clinician could still be the chair or deputy chair—just not one from within that HHS. It could be that the chair or deputy chair role is fulfilled by a clinician who, as I mentioned before, works in private practice within the HHS, works within primary health care or works in a neighbouring HHS. That is really why the amendment proposed is to not have the local clinician board member able to fulfil either of those two roles. It is about supporting the management of those conflicts of interest that might eventuate in relation to the service-level agreement or having the casting vote.

Ms BOLTON: Is there any risk having a local clinician versus somebody from outside of that HHS? Is it not having the ability to have that outside view or are they are a bit too close?

Ms Bryant: To clarify, member for Noosa, is there a risk that if the clinician from outside the HHS is the chair—

Ms BOLTON: No, my apologies. In having local clinicians versus someone outside the area, are we losing the ability for an outside perspective to see issues clearly?

Ms Bryant: There are at least five board members on each one of the boards. As we move through the recruitment process we are about to begin for the 2026 board appointments, in terms of the skills matrix and capabilities we want to have on the board a balance between a local perspective and an external perspective.

CHAIR: It may be helpful to have the Integrity Commissioner come along and comment on some of these issues. There are some issues that are conflicts, but that does not mean an oncologist cannot talk about oncology issues and provide advice to a board. There are a few grey areas and some lines where I think we get a little bit worked up about conflicts. If that is a genuine matter of concern for the committee, maybe we should invite the Integrity Commissioner to come and provide some advice. I will move to the member for Redcliffe for questions.

Ms DOOLEY: My question is also around the HHS board. Can you outline the advantages of having local clinicians who are currently in clinical practice? I am very aware that boards often have people who have moved from clinical roles into more administrative or legal roles. Can you talk about the advantages you see with those who have current clinical experience?

Ms Bryant: I will start and then Karson can add to my response. As I outlined in my opening statement, part of the advantage is having that uniquely local perspective around how to address some of the performance issues, how to improve service delivery. As many of you might appreciate, we have 16 hospital and health services that are statutory entities. They really do aim to not only shape the way their services are delivered to deliver on the unique community needs of that community but also shape those services in the way they are delivered in partnership with the network of services around them in that community. One of the benefits of having a local clinician on the board is that they will be able to speak to the operations within at least one of the facilities in that hospital and health service. They will also be able to speak to, and provide perspective on, how that interacts with the network of other services within the community and how that can work well—and maybe even better—to meet the needs of local community members. I might just pause there and check whether Karson wants to add to that in terms of the advantages of having local clinicians on the board.

Mr Mahler: I think you have covered it. For all those reasons you say, there are a lot of advantages. I would just reiterate the point that this is not a mutually exclusive proposition. There is still the ability to have both a local clinician and an external clinician or a clinician within the same HHS who is working in private practice. That brings different perspectives. There are not only all of those advantages; they complement the existing clinical perspective that might already be on the boards that we would be looking to retain.

Ms DOOLEY: Are you aware if this is done in other states in Australia?

Ms Bryant: I am not aware that it is happening in other states and territories. That may be one we have to take on notice. Other states and territories have clinicians on their boards. They have requirements, as we have outlined, that clinicians have recency of practice and are registered under the health regulation national law.

Mr Liddy: I was just going to add to what Peta had to say. Every state and territory has its own legislation that is specific to that jurisdiction, so each one is set up slightly differently. In looking at these amendments, we did not find there were other states and territories that mandate having a local clinician on the board. In that sense, Queensland is moving ahead of the other states.

Dr O'SHEA: Thank you for the briefing and thank you for coming today. I want to commend Queensland Health for the work they are doing in getting vapes off the streets. Hopefully, we can starting seeing youth usage levels coming down. I have three quick questions. With the insertion of new section 223A(1), I can understand recovering costs for storage, destruction and even for investigation, but is there precedent for accused persons to pay for the cost of their prosecution?

Mr Mahler: There certainly are precedents. I have some information here, if you will bear with me. As a general proposition, courts usually have some discretion to award costs in litigation. In terms of costs associated with destruction and forfeiture of vapes, there are provisions in some other legislation that have a similar type of framework. The legislation has comparable types of powers around forfeiture, including the Police Powers and Responsibilities Act but also, maybe more analogously, the Explosives Act 1999 and the Customs Act 1901, which is Commonwealth legislation that also deals with tobacco products and vaping goods. Where there are dangerous types of goods—chemical and things of that nature—often the legislation will provide for a more expedited or expedient type of process for seizing and destroying those products. That just recognises that these are dangerous products and it is not reasonable to expect that the government would hold on to these things and incur all sorts of costs associated with doing that.

In terms of cost recovery for these types of things, I do not have specific examples in front of me right now, but we have looked at comparative provisions in other legislation. This is not a unique provision. There are some other precedents for this. Stepping back to the policy rationale for these reforms, we are talking about activity that is occurring in a highly illicit space. When we talk about vaping goods, they are nationally prohibited. It is very clear that we are talking about contraband.

These products should not be out there. When they are found, particularly given some of the comments Mark made around the costs and inconvenience to the government in terms of storing and holding onto those products, it is quite significant.

I should emphasise that these provisions only apply to persons who have gone through a full judicial procedure, so they have been convicted of committing a supply or possession offence, a commercial possession offence, and the court has the discretion to award reasonable costs associated with investigation and enforcement. It is within the discretion of the court, so the court would look to a range of factors. It would not be the case that in every prosecution costs are awarded. They would look at how egregious was the conduct, whether it was repeated or systematic, and what steps the person took throughout the litigation. Were they trying to delay the litigation or make it difficult for the government to proceed with litigation? There are some safeguards built in in that respect. To answer your broader question about other legislation, I would be happy to go back and provide more detail on notice in terms of comparable legislative schemes if that would be helpful.

Dr O'SHEA: Yes, just purely on cost recovery for preparation of a prosecution case. I think it is completely reasonable for people to pay for costs associated with storage, destruction and investigation, but I was just wondering if there are any precedents for that.

I am looking at the insertion of new section 205B(3), the chief executive not being required to provide procedural fairness in giving a written notice. I understand that currently when items are seized there is a show cause, there is a proposal to forfeit, and then the original owner of the property can put in a written response to that show cause notice and appeal to the Magistrates Court within 28 days. Obviously, the need to destroy these very hazardous materials rather than store them is paramount. In terms of procedural fairness, because the bill removes show cause and an appeal process, could it be said that there is still an ability to appeal even if the items were destroyed rather than just removing natural justice completely?

Mr Mahler: I should clarify that the bill does not remove a person's appeal rights. If you are found to be in commercial possession of a vaping product or supplying and products are seized, you could still appeal. The bill essentially provides that the department is not required to hold the goods until the end of the appeal process before it destroys them, so destruction can happen up-front. The person can still appeal. If the court finds that the items were wrongfully seized then the person has a right to seek compensation in that instance. There is some procedural fairness and natural justice built in. There is still a remedy in the unlikely event the vaping goods were unlawfully seized.

I would make a couple of other points as well. These goods are extremely easy to identify. It is very clear whether they are illegal or not. As Mark said, the only lawful vapes in Australia are your plain packaged, pharmacy-only supplied vapes. A vape is intrinsically very obvious to identify with its cartridge and ignition and all the rest of it. Because the Commonwealth scheme is so strict in terms of who can possess and supply these products, there is very little opportunity for genuine mistake of fact. It is probably quite unlikely, but, nevertheless, it is important that there be natural justice, so the bill does not remove that. It just rebalances the way we handle these seized products. They can be quickly destroyed so the department does not have to hold them. The defendant still has the ability to appeal and seek a remedy if something does go wrong.

CHAIR: In the interests of time, we need to keep moving. I will go to the deputy chair in just a moment, but the member for South Brisbane raised some questions about process. Perhaps as a question on notice you can provide a bit of detail on the process of how you identify and then what actions you take, who is involved in that—I assume the police are there as part of raids or part of that process—then what the steps are. It would be helpful to see that process. The other question in my mind is in terms of cost recovery. I assume we do not only seize illicit products. There may be times when there is a raid and cash and other things are seized. I would be curious to see how all of that is managed and how it parallels to processes around other illicit substances seized by the police or other areas of enforcement. I will go to the deputy chair.

Mr J KELLY: Chair, we are happy to go a further five minutes since we were late starting today. In relation to the cost recovery, who is held accountable? Is it the business or the individual?

Mr Mahler: It would be the party that is charged with the offence. The cost recovery can only apply if a person, or a company as a legal person, has been prosecuted for an offence under TOSPA and has been convicted. The court, in that instance, then has the ability to issue a costs order. Typically, it would be the corporate entity. In terms of enforcement, generally Queensland Health and police are going after the business, not the cashier or the person working for the business.

Mr J KELLY: Mark, you have obviously been involved in enforcement issues around this. If it is a business, are they not going to use their limited liability to try to get out of paying this, and what is the capacity of individuals to pay if they simply say, 'We have no money'?

Mr West: That is an enforcement challenge, definitely. The Tobacco and Other Smoking Products Act is comprehensive in that it covers all persons, be they individuals or businesses. We most certainly want to disrupt the business model. We want to go after business. The highly skilled environmental health officers in public health units all across Queensland, with their management, pull together briefs of evidence as strong as possible to identify the correct business entity, and that is the entity we go after.

Mr J KELLY: Given that we know, or at least there are reports in the media, of organised crime being involved in this sector, is Queensland Health working with Queensland Police in relation to these matters? If you go in and go after Joe's tobacconist store—which is still, mind you, advertising vapes in my electorate, and I thought that was illegal—are you working with Queensland Police in terms of the organised crime elements that are involved here, because it is very easy to leave an individual out to dry while the real culprits get away?

Mr West: Exactly right. Yes, we are. Our response to vapes is both national and local. We work with Australian Border Force, Customs, Australian Federal Police and the Therapeutic Goods Administration, TGA, in trying to stop the vapes at the border to begin with because they flood into the market. Earlier we talked about supply and demand. There is a demand for vapes, so we are trying to address the supply side of the equation. We all collaboratively work together nationally.

We work closely with the Queensland Police Service, who do a great job in supporting Queensland Health, especially in high-risk environments. Our Queensland Health environmental health officers will do a risk assessment of a premises they may know about through community complaints—people can log them online—or from their own intel, from their own inspections in their communities. If they are going out to Warwick or somewhere else, we get feedback about what is going on in the space. They do a risk assessment around health and safety, because we do not want to put our Queensland Health officers in harm's way. It is their job they are enforcing.

In most circumstances, the risk is low to medium because, as we generally find, there will be a vape shop with a 19-year-old person sitting on their phone doing Instagram and social media, they do not know who their boss is and they get paid by someone who comes around with some money, but they are still supplying. We have to use our investigative skills through location, other intel, even from the police when we can source that information, to go after the business. Yes, there might be a 19-year-old salesperson in the shop, but they are not our main concern. Our concern is the shopfront and trying to get rid of the shopfront.

Mr J KELLY: Coming back to the HHS boards, in relation to the Integrity Commissioner, has advice been sought in relation to this structure of board that is being proposed?

Ms Bryant: Advice from the Integrity Commissioner about the amendment?

Mr J KELLY: That is correct.

Ms Bryant: The Integrity Commissioner has not been consulted on the amendments to the bill. We talk with the Queensland Integrity Commissioner about ways of supporting the hospital and health service boards quite frequently as part of our normal course of business.

Mr J KELLY: Was there any external advice sought in relation to the structure of this board?

Ms Bryant: The chairs were consulted and it is a public commitment, so it is quite well known that this amendment is going forward or will be proposed to the parliament.

Mr J KELLY: That is well understood, but the question is clearly there has been no external advice in relation to the structure of the boards?

Ms Bryant: The chairs are external to our department, member for Greenslopes, and their advice has been sought around both the implementation timeframes and what this change could look like.

Mr J KELLY: But they may not necessarily have the sorts of qualifications that might allow them to provide that advice. Have you gone to the Australian Institute of Companies or—

CHAIR: You are straying a little bit, member.

Mr J KELLY: In your opening statement you said there was a major round of recruitment occurring at the present time. Why do you have so many vacancies on the HHS boards at the present time?

Ms Bryant: Some of them are not vacancies; some of them are due for reappointment. We will start that process in June. We will begin by working with the chairs, based on their skills matrix, to understand the capability gap or skills gap that they might have if a board member is planning to step down or not seek reappointment. If we know that the board appointment time frame or time horizon for those members is coming due, we will be talking to the chairs about, if a board member does not seek reappointment, what that looks like. That informs an expression-of-interest process. Once we do the expression-of-interest process, if this bill is passed, we would be trying to promote that EOI process with clinicians. It is part of our normal course of business that every two years we would have a number of reappointments to do and we would work through that.

Mr J KELLY: Have there been any terminations of positions by the new minister or government and what are the reasons for those?

Ms Bryant: Any terminations of board memberships?

Mr J KELLY: HHS board positions since the new government has come to office.

Ms Bryant: No, not that I can recall.

CHAIR: We are out of time. We have a number of questions taken on notice, and the responses are due by 4 pm tomorrow. The secretariat will get you a summary of those questions by 2 pm today. That concludes this briefing. Thank you to everyone who has participated. Thank you to our Hansard reporters. A transcript of these proceedings will be available on the committee's webpage in due course. I declare this public briefing closed.

The committee adjourned at 12.37 pm.