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:
Ms K Jones—Committee Secretary
Miss A Bonenfant—Assistant Committee Secretary

PUBLIC HEARING—INQUIRY INTO THE HEALTH LEGISLATION AMENDMENT BILL (NO. 3) 2025

TRANSCRIPT OF PROCEEDINGS

Wednesday, 19 November 2025

Brisbane

WEDNESDAY, 19 NOVEMBER 2025

The committee met at 9.30 am.

CHAIR: Good morning. I declare open this public hearing for the committee's inquiry into the Health Legislation Amendment Bill (No. 3) 2025. My name is Robert Molhoek. I am the member for Southport and chair of the committee. I acknowledge the Aboriginal and Torres Strait Islander people of this state and their elders past, present and emerging. I also acknowledge the former members of this parliament who have participated in and nourished the democratic institutions of this state. Finally, I acknowledge the people of this state, whether they have been born here or have chosen to make this state their home and whom we represent to make laws and conduct other business for the peace, welfare and good governance of this state. Other committee members with me here today are Mr Joe Kelly, member for Greenslopes and deputy chair; Ms Sandy Bolton MP, member for Noosa; Ms Kerri-Anne Dooley MP, member for Redcliffe; Dr Barbara O'Shea MP, member for South Brisbane; and Mr David Lee MP, member for Hervey Bay.

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 or affirmation, 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 of 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 direction at all times. You may be filmed or photographed during the proceedings and images may also appear on the parliament's website or social media pages. I ask members and witnesses to please remember to press your microphones on before you start speaking and off when you are finished, and please turn your mobile phones off or on to silent.

YIM, Dr Nick, President, Australian Medical Association Queensland (via videoconference)

CHAIR: Good morning. Would you like to make a brief opening statement before we start our questions?

Dr Yim: Good morning, everyone. Thank you for the invitation to appear today. As well as being the President of the AMA Queensland, I am also a GP in Hervey Bay. AMA Queensland has provided feedback on various amendments in the current bill which have been on foot for some time which we broadly support. As such, my comments today will be confined to just the more recent proposal relating to the Private Health Facilities Act 1999 and the regulation of private health facilities providing cosmetic surgery.

The committee will no doubt be aware of the recent federal government guidelines to improve safety of cosmetic procedures. These were brought in to address significant concerns about patient safety in the field of cosmetic surgery and were widely supported by doctors, including plastic surgeons. The current bill complements those reforms, particularly regarding the administration of cosmetic injectables. Doctors are increasingly concerned about the regulation of non-medical facilities delivering cosmetic injectables and the risks for patient safety. Sadly, I have had colleagues advise me of patient harms with inadequate regulation, including facial paralysis and death. I have also been told of poor practices regarding medicines handling, including the inappropriate sharing of botox vials among patients by staff and unsafe transportation.

While I understand that these cases have occurred across Australia and are not confined to Queensland, they show there is a clear need for better regulation. As a GP and practice owner, I must adhere to strict requirements of medicines handling and storage as part of mandatory accreditation for my practice. All medical and dental practices are required to uphold these standards to ensure patients are not harmed when they come to us for treatment. We must also maintain the capacity to respond to adverse patient events when they occur, including anaphylaxis training and response management. Patient safety is paramount and must apply no matter the setting in which treatments are given. There is no reason why all private facilities and people providing cosmetic surgery services should not have to adhere to these same essential requirements as required by doctors and dentists.

I would also advocate for all non-medical prescribing, including for cosmetic injectables, to be required to be done in collaboration with a doctor. Time and again, research has shown that collaborative models are the safest and most appropriate way to protect patients from harm.

Finally, I draw the committee's attention to the risk that continued inadequate regulation is highly likely to lead to a proliferation of exploitive and unsafe single-issue business models. This is what we have seen through poor regulation of medicinal cannabis, and the same factors are present in the rapid rise of non-medical cosmetic injectable services. We urge the committee to recommend the government implement reforms that address these concerns and protect patients from further harm. Thank you for your time. I am happy to answer any questions.

CHAIR: Thank you.

Mr J KELLY: Thanks for your time this morning, Dr Yim. I started the day listening to you on the radio talking about hyperbaric chambers, so good work there too. You are a busy man. Can you step us through some of the risks around the impacts of cosmetic injectables, particularly around the facial region, and what can go wrong?

Dr Yim: First and foremost, we can go through the common risks and obviously the life-threatening risks that can occur. As I alluded to in my submission and my statement, a common risk that can potentially occur is facial paralysis. That can be short term in that it may last for hours to days, but at the same time it can be long term and permanent. At the other end of the spectrum, there can be anaphylactic reaction. What that means is an individual may have an allergic reaction to an injectable that may affect tongue swelling, breathing or shortness of breath and if facilities do not have the capability to respond to those issues it can cause catastrophic harm.

Mr J KELLY: I have done a bit of botox in a rehab setting and I was not fully across the anaphylaxis risk. I thought it was more the risk of the actual injection and where you are putting that in terms of nerves, but that is interesting. The issue you raise around integrated business models is of great interest to me and I am sure other committee members as well, and we have run across that recently. There are some vaping cessation businesses that seem to tell you what is wrong with you, tell you what the treatment is, sell you the treatment and then usually continue to sell you more of the same treatment without you ever getting better. Is that what you are concerned about here in an injectables cosmetic surgery context?

Dr Yim: That is one of the big reasons for concern. Obviously we have seen the single-issue models, as you alluded to, with vaping. We have seen it with medicinal cannabis, and patients and individuals need to be treated holistically. It is a treatment. It is an injectable of something foreign into an individual. People must take into account the person's whole medical history and whether they have potential other medications that may interact, but at the same time there are also mental health issues that they need to be aware of. This is the reason we need to ensure there is collaboration in this space, to ensure patient safety.

Mr J KELLY: I was going to ask about that. In terms of plastic surgery more so than cosmetic surgery, if someone approaches for a treatment, one of the things you might consider, I guess, as a clinician is that there may be no physical reason to do the surgery but there may be a mental health or an emotional reason to do the surgery but also it might have impacts on the person. Is that a factor in this as well, that people really should be considering why people are seeking these treatments and whether or not this is appropriate for them?

Dr Yim: That is correct. There has been a change in legislation in the cosmetics area. If people are looking for surgical methods for changes to their body, a mental health assessment needs to take place to ensure there is no underlying mental health issue or diagnosis that might be leading them down that route. If there is, that might not be the best route for that individual.

Ms BOLTON: Good morning, Dr Yim. I want a bit of a better understanding around the issue of cosmetic injectables. Do we have any data on the percentages? You spoke about facial paralysis as an example. Do we have any data as to the percentage impacted if they are attending, say, a local clinic with reports by qualified nurses and consults done online with a GP? In that setting I am after the difference in the percentage who report that they have had facial paralysis versus the type of model you are talking about that, from my understanding, would require a GP to be onsite.

Dr Yim: Apologies, but I do not have the physical numbers. This is going to be one of the challenges we may face, because currently it is an unaccredited space. Currently there are some practices that are joined with a general practice, for example, that use the accreditation as well—

those standards—but at the same time there are unaccredited practices that are administering injectables. I know that my colleagues from the Society of Plastic Surgeons will be presenting later today. They might have the actual numbers or anecdotal numbers, but I do not have those to hand.

In terms of the model proposed, they are models that can be supported. The key thing here is that we are seeking collaborative models to ensure there is collaboration with that medical practitioner to ensure there is safety involved to assess the medical conditions of the individual and also medications to ensure there are not any interactions that may occur.

Ms BOLTON: That collaboration can be online; it does not have to be physically at the particular sites in the clinic?

Dr Yim: In terms of online collaboration, it really depends on the risk of the procedure, and this is where guidelines will come in. For major procedures that may be high risk, there may be a need for an onsite or physical examination. At the same time, if the injectable itself is low risk and in a low-risk area, you are absolutely right in that an online or telehealth type model may be appropriate.

Ms BOLTON: With any stricter regulations, what types of adverse impacts will there be on the workload for cosmetic surgery practices but also doctors, given that we have a severe shortage of GPs and doctors? Within my own community, for anyone new to the community it is near impossible to get in to see a doctor. If we are asking for an increase in the use of doctors, how is that going to be offset to not further impact on our other waitlists?

Dr Yim: I think we have to remember that cosmetic surgery on the whole is an elective procedure. Whilst I acknowledge that the workforce is challenging, many medical practitioners are participating in the cosmetic space already. What we are calling for is to ensure we have safety standards and also review standards so we can monitor this space and to put the patient or the individual at the forefront and safety at the forefront.

Mr LEE: Good morning, Dr Yim. It is great to be talking to a fellow Hervey Bay resident. Earlier you touched on what I understood was shared vials of botox. Are you aware of any cases where there has been transmission of infection as a result of that practice?

Dr Yim: We are unaware of any cases of infection or shared viruses, but, as you allude to, this is one of the great concerns. In a general practice setting there are strict checks and balances with regard to the sharing of vials. This is something that is highly not recommended. That can lead to shared viruses and transmission of bloodborne viruses, which is concerning. It will be hard to track. That is the reason we need those standards in place.

Mr LEE: Are there any further issues that you think need to be addressed within the bill? Are there any further amendments to address concerns that you have?

Dr Yim: AMA Queensland broadly supports the bill as it stands. This is something we have worked on and we broadly support.

CHAIR: We are out of time. I note that the member for South Brisbane has a quick question.

Dr O'SHEA: Good morning and thank you for all of the work that you do with AMA Queensland. Are cosmetic injectables included in the definition of cosmetic surgery in terms of the bill?

Dr Yim: I apologise that I do not have that answer to hand. That is probably something I could take on notice.

Dr O'SHEA: I am imagining from your submission that what you would like to see is them viewed as part of cosmetic surgery in terms of safety and regulations for oversight for patients.

Dr Yim: Correct. We do want safety at the forefront. Accreditation standards are key. To use a crude example, things that require a hospital procedure—major surgery that is done by our plastic surgeon colleagues—are going to be different from, say, an injectable into the face. There are going to be different accreditation standards for different procedures.

Dr O'SHEA: Thank you.

CHAIR: Thank you. We will place that on notice, if that is all right. Thanks, Dr Yim. We need to keep moving along, in the interests of time. We appreciate your appearance here today.

PAGE, Mr Stephen, Secretary, Fertility Society of Australia and New Zealand

CHAIR: Good morning. Would you like to make a brief opening statement before we start our questions?

Mr Page: Thank you and good morning. Thank you for asking me to speak. I acknowledge the traditional owners. I am a dad through IVF, a known egg donation and surrogacy, all of which occurred here in Brisbane. I am a solicitor who has long specialised in fertility law. I am a member of many committees and, most significantly in this case, secretary of the Fertility Society of Australia and New Zealand. When I wrote my submission I did so in a personal capacity, but I speak today on behalf of the society.

While the ART bill had bipartisan support, it was a rushed process. Things have been found that, in retrospect, with a slower process would have been discovered before enactment. I do not criticise the ART review team of Queensland Health, who, in my view, did an excellent job in the circumstances, as I told them on the day that the bill was passed by the House.

I support this bill so far as it deals with amendments to the ART Act and the Transplantation and Anatomy Act, and I do not comment about the rest. I do not know them. The two bigger changes for the former are: to overcome the issue with the Xytex donors—that is the US sperm bank—so that there is not such a prescriptive regime as to how donors can be contacted; and to recognise that if couples have split up they should not be counselled together. The latter issue was brought to my attention by Ms Evelyn Zwahlen, a very experienced fertility counsellor, who pointed out that counsellors would not counsel a couple together when their relationship was at an end.

Looking at that requirement, while on separation a de facto partner is no longer a spouse; the same is not true for those who are married or in a civil partnership. Despite separating, their legal relationship continues until the relationship is dissolved. The requirement to counsel a couple together, aside from being awkward or inconvenient, could be unsafe and unlawful—for example, in breach of a protection order and in breach of the Commonwealth's Sex Discrimination Act.

I do not know much about organ transplantation, but I am experienced with posthumous sperm retrieval. Issues have arisen where the deceased is an organ donor and his widow wants to retrieve his sperm. Anything sensible that might make the transplantation process easier, as the amendment to the Transplantation and Anatomy Act appears to do, is welcome. I want to acknowledge the efforts of Dr Douglas Feinbloom at Caboolture Hospital, who had the foresight to write up a quick guide after the enactment of the ART Act to transplant teams when faced with these competing demands. He contacted Kate Cooper of Monash IVF and me. Each of us provided input. I am delighted that his guide is now at hospitals across Queensland, making it easier to enable both organ donation and posthumous retrieval.

CHAIR: Thank you. I will go to the member for Redcliffe to kick off the questions.

Ms DOOLEY: Thank you, Mr Page. Thank you for appearing this morning and for your submission. Are you aware of any current legal challenges arising under the ART Act?

Mr Page: No, I am not. I have certainly heard there has been some chatter, but I am not aware of any particular cases at the moment.

Ms DOOLEY: What was the policy reason for including a maximum 15-year period regarding donated gametes?

Mr Page: I do not think there is any precise answer to that. My recollection—I was involved in the stakeholder discussions on the way through, not a decision-maker for it—is so that there was a practical period. What I have certainly seen in practice since then is that I have had clients who have been impacted by that. I think the bill, which gives flexibility about that is, is welcome.

Ms DOOLEY: Are there family limits in other Australian jurisdictions that you are aware of?

Mr Page: Yes. The society is on record saying that there should be one system for regulation of IVF Australia-wide, not eight that we currently have. We had Greg Hunt and Rachel Swift write a very good report calling for that. Health ministers, of course, have said, 'Go off to the ALRC about donation. We should have accreditation.' The overall regulation has not been dealt with in this bill, in the previous bill or nationally.

One of the things we see is that there is great variety about numbers. Queensland I think has the most generous number, and this bill makes that even more flexible, which is welcome. New South Wales says five women. How I read the New South Wales act is five women in New South Wales, but NSW Health says it is five women everywhere. That caused a crisis earlier this year with New South Wales IVF clinics and is likely to lead to New South Wales women accessing private,

unregulated sperm donation. That, for me, is the great worry about this space: there is no regulation there. Health ministers have said it is going off to the ALRC. It has not yet been referred to the ALRC and it has in essence been kicked off into the long grass. I expect that New South Wales women will make more access of Queensland IVF clinics as a result because of our difference.

Victoria is 10; ACT is five in the ACT and 10 nationally. In Tasmania the clinics have adopted five, because Tasmania is isolated and small. South Australia is under the NHMRC ethical guidelines, which is roughly seen as 10. It is the same in the Northern Territory. Western Australia is five worldwide. Western Australia has a bill currently going through the upper house which has the same effect. You can see that it is quite different.

CHAIR: Can we perhaps get a copy of that report that you reference?

Mr Page: Absolutely.

Dr O'SHEA: Thank you very much for the work that you do in this space because it is a very sensitive area, particularly so with the posthumous collection of materials. Thank you for supporting people going through that process. I am just looking at the changes to the act about the definition of contact information that will be kept. At the moment it is address, phone number and email address. The amendment goes to address, phone number or email address or any other way the person may be contactable. Was there any discussion, that you know about, about what that could cover?

Mr Page: None. When I looked at the 2024 ART bill I thought, 'That's pretty sensible.' Of course, it said it should apply to sperm, eggs and embryos created before the commencement date. In March or April, Monash IVF and Queensland Fertility Group identified a problem because women had imported sperm from a US sperm bank, Xytex, and Xytex had not got the details of email address or mobile phone number because there was no obligation to do so. Suddenly, at least one of the clinics was saying to patients, 'You can't use.' Then Queensland Health came up with a bandaid: 'Well, you can use, because we don't want patients to be disadvantaged,' but on the face of it it appeared to be unlawful. This fixes that. I think this change is very sensible.

Dr O'SHEA: Do you feel, though, that donor-conceived children—and adults later—will have difficulty trying to access that information if it is a bit vague about 'or any other way the person may be contacted'?

Mr Page: I would expect that, in terms of local donations, the clinics will be rigorous in getting that information. The issue is more about the importation of eggs and sperm because they are imported into Queensland from overseas places. The three places that stand out to me are the United States, Malaysia and Ukraine. I would expect that that information would be provided. I know that in terms of one of the clinics, they were quite—'burnt' is probably too hard a word but they were certainly wary about ensuring that in future they get that information. I would hope that the other clinics have also learned that lesson.

Ms BOLTON: You mentioned earlier the rush in the last inquiry. With these amendments now, what else is left in this space that needs to be addressed, or have these amendments remedied what was left out, first of all?

Mr Page: You may recall that back in 2022 I was asked by Mr Russo, as I recall it, about private sperm donation. At that stage I took the view that that was the worry but it could not be regulated. I have a view about how that could be regulated—primarily by the Commonwealth in cooperation with the states and territories. You cannot regulate someone meeting at a pub or a coffee shop or by phone, but you can regulate the websites and apps. That is the way to do it. I worked out a couple of years ago how to do it when I saw a very concerning article about a bloke down south who created over 60 children through private sperm donation using four aliases. A criticism I had of the ART bill was that it did not allow—and does not allow—the registrar of Births, Deaths and Marriages to give information to interstate central registers. Each central register is its own silo and, therefore, we do not have a real idea about the cap on numbers nationwide. We just have no idea about whether there has been compliance.

Ms BOLTON: Last time, the concern with the legislation was that the number of those websites and private sperm donors would rise. Have we seen any increase?

Mr Page: Absolutely. One site, according to the ABC, had over 20,000 members and as of November last year there had been over 2,000 children born through the donors in that site nationwide. Those numbers are just huge. What I worry about is the children who are born who discover one day, 'I have 60 siblings that I never knew about.' There is no national central register, and the central registers we currently have or are about to have—Western Australia, South Australia, Victoria, ACT, New South Wales, finally here, but none in the Northern Territory or Tasmania—do not

talk to each other. The only one that talks to each other, from changes in the law last year, is New South Wales, but ours does not. That was a criticism I had of the ART bill. This bill is good—I support it and the society supports it—but it does not cover that issue. What we really need is one system of regulation of IVF and donation and one national donor register.

CHAIR: It sounds like there might be a need for some harmonisation legislation. It is probably something for the ministers to talk about at COAG. Is the ALRC doing a report on this?

Mr Page: The Australian Law Reform Commission has two inquiries currently under its belt: the human tissue inquiry—I certainly made a submission to that. They are suggesting that posthumous sperm retrieval be taken out of the Human Tissue Act—in our case the Transplantation and Anatomy Act. Queensland has already done that. We have put it in the Assisted Reproductive Technology Act. I played a key part in that. I think that is good. Interstate, that might be problematic. The other inquiry is the surrogacy inquiry. I am on the advisory committee for that. It has just issued its discussion paper and it is due to report in July next year. The health ministers met and agreed that the ALRC would have referred to it issues about donation, so sperm, egg, embryo donation and the regulation of that. That referral I understand has not yet happened. Presumably there has to be an allocation of money and resources for the ALRC to do it before there is a referral.

CHAIR: Thank you for your submission and for making yourself available today.

WON, Dr Rebecca, Honorary Secretary, Australian Society of Plastic Surgeons

CHAIR: Good morning. Would you like to make a brief opening statement?

Dr Won: I would like to make an opening statement. It is likely to run slightly over the three minutes that is usually anticipated, but I think it is important that we discuss it because it provides context to the legislation being discussed today. I am Dr Rebecca Won; I present today in my capacity as executive council member and honorary secretary of the Australian Society of Plastic Surgeons. I am joined here by our CEO, Mr Kim Hanna. We represent over 600 specialist plastic surgeons in Australia of which over 100 are in Queensland. We serve approximately 200,000 Australians every year. Our members perform both reconstructive and cosmetic plastic surgery so that members of our community can regain functional capacity and personal confidence and thrive in their communities.

Personally, as a specialist plastic surgeon I perform cosmetic surgery for private patients, with consultation in my private rooms and surgery performed at Greenslopes Private Hospital, Mater Health and Brisbane and Spring Hill specialist state hospitals, so a combination of inpatient and day hospital facilities. I also provide public plastic surgical reconstructive services as a VMO at Royal Brisbane and Women's Hospital. I care for patients who have found themselves there after suffering significant harm from cosmetic surgery. In a number of circumstances that harm has been enabled by the lack of facility regulation, which we are here today to rectify. The diversity in my scope of practice allows me to comment on how regulation can affect patient safety from a number of different perspectives. We welcome the opportunity to appear here today in pursuit of addressing these regulation gaps with the aim of making cosmetic surgery safer for Australian patients, but we would like to add some context to this specific regulation being discussed.

In October 2021 the mainstream media broke with a program called 'Cosmetic Cowboys', which depicted what ASPS members already knew had been occurring for some time; that is, there was a failure of the health system in which we were operating. In September 2022 Ahpra and the Medical Board accepted all 16 recommendations of an independent review. The health ministers then agreed to four urgent actions.

The first action was to protect the title of surgeon. I have appeared before this committee previously to discuss that. Essentially, that resulted in legislation being passed to say that only medical practitioners who hold specialist registration in surgery, obstetrics and gynaecology or ophthalmology can call themselves a surgeon. It is worth noting that that regulation addresses titles only; it does not restrict who can actually perform the surgery. Despite that difference, the change has had a really material impact. Patients always understood that the title 'surgeon' inferred the highest level of training and ability, and the new law now aligns with that. Those who are not sufficiently trained can no longer hold themselves out as surgeons and mislead the public. We have welcomed the education campaigns that Ahpra have been putting forward to the public which basically further enhances their understanding.

The second action was area-of-practice endorsement. This endeavoured to set out the minimum training standards considered necessary by the Medical Board of Australia to safely perform cosmetic surgery. It was intended to help patients identify who is appropriately qualified to perform the surgery by displaying it publicly on the Ahpra website. It has never been expected, nor required, that fully qualified surgeons, fellows of the Royal Australasian College of Surgeons or equivalent, sought endorsement because their level of training is implicit in their ability to use the title. Since the implementation of that endorsement action in July 2023 the Medical Board has not approved any programs of study for endorsement; nor have any medical practitioners been endorsed. At this point in time, that action really has failed to achieve its aim.

The third action related to advertising guidelines. Cosmetic surgery advertising guidelines that were developed by the Medical Board and Ahpra became effective in July 2023. The national law was amended, with maximum penalties up to $60,000 for an individual. This had a significant impact and has contributed to reducing the risk of patients being coerced or induced into undergoing invasive surgery where the risks were often downplayed and outcomes overstated.

That brings us to the fourth action, which is why we are here today: licensing standards for facilities. This is what we are addressing now, four years after the initial media first broke. I think in view of Dr Yim's earlier comments it is worth clarifying that this facility regulation we are discussing relates to cosmetic surgery, which is defined as cutting beneath the true skin. It is not applicable to cosmetic injectables. If it were to be applicable to cosmetic injectables, you would be saying that all cosmetic injectables would need to happen in a hospital. I do not think that is anything everybody wants due to our access issues. As yet there has not been any regulation passed about licensing standards for facilities, so it has not had the chance to be effective.

ASPS agree that this regulation is a really important piece of the puzzle in improving patient safety and we support the intent of the proposed bill. We understand the nature of the legislation, its place in the bigger reform process and the fact that it will likely pass. We do, however, have some serious concerns about the proposed way it will be implemented. We wish to put on the public record the risks and issues we foresee occurring if it moves forward unaltered.

The review of licensing standards of facilities led the Australian Commission on Safety and Quality in Health Care, or the ACSQHC, to create a separate cosmetic surgery standard in addition to an existing standard that already applies to all other surgical operations. That existing standard is set out by the National Safety and Quality Health Service Standards, or the NSQHS Standards. In essence, the facility regulation for cosmetic surgery has been duplicated rather than included within the existing national regulation that applies to all other forms of surgery. If the bill today passes then the duplicated regulation will apply to all private facilities in Queensland.

The administrative burden the new standard imposes on hospital administrators is really quite significant when you compare it to the low number of cosmetic procedures carried out in any year. It is a burden that is quite likely to lead to local facilities ceasing to provide cosmetic surgery in order to avoid the additional burden it imposes. This will particularly affect the smaller day hospital facilities in which many of these procedures occur and it will lead to access issues for patients. If they cannot have it done in a small community facility that is appropriately accredited then they will have to go to a larger hospital. That then puts pressure on waitlists and access to care.

Commonly, the only difference between cosmetic surgery and reconstructive surgery is simply the reason for performing it. The surgery is actually the same, with the same risks of complications and the same recovery, so creating a parallel and duplicated system of accreditation further promotes the false concept that it is somehow unique. If the legislation passes as it is, we are going to have a situation where, if you were having an abdominoplasty—a tummy tuck—because your tummy muscles are 2.5 centimetres separated then that will be considered cosmetic and you will be under the cosmetic surgery facilities regulation, but if those same tummy muscles were three centimetres separated that would be considered reconstructive and you would then be under the existing facilities regulation. If you had a rhinoplasty to correct a deviated septum because it was crooked, that would be considered reconstructive and you are under existing regulation, but if you are doing it just because you want your nose to look different then it will be cosmetic regulation. Prominent correction in a 17-year-old would be reconstructive but cosmetic in an 18-year-old. I can provide many other examples, but they highlight our firm belief that cosmetic surgery is a subset of surgery and therefore there is no need to have a separate cosmetic surgery standard.

We want to ensure that Australians can access these procedures in settings close to their homes and support networks. We have high standards of health care and surgical care in Australia and we are the envy of many other developed nations. We do not want to see Australians being forced to seek cosmetic surgery overseas—where the standards can be significantly lower and the harms greater—as a result of access issues that have been created by excessive, duplicated regulation at home. It is us, after all, who look after these patients when the current system fails them and the Australian taxpayer who pays.

We recommend that the government, in conjunction with the states and ACSQHC, revise their approach to this facilities regulation for cosmetic surgery and incorporate it into the NSQHS general standard. Use the regulation that already exists rather than duplicate it. Doing this will still achieve the original aim of addressing the system gaps identified back in 2021. It will avoid unintended disadvantageous access issues. The existing accreditation standards that ensure non-cosmetic surgery is safe will also ensure cosmetic surgery is safe.

CHAIR: We really have no understanding of the difference between facilities. Can you explain the additional burden?

Dr Won: When we talk about facilities, we are essentially talking about hospitals. The two main types of hospitals are inpatient hospitals, where you can stay overnight, and day hospitals, where you can have your surgery, recover and go home the same day. They do not necessarily have the capacity for you to stay overnight. The extra burden that comes in the extra regulation and things that are above and beyond the existing standards include things like the facility having to have processes to ensure their clinicians are assessing patients' suitability for surgery. As a professional, in my private consulting suites that is what I do. The fact is that the facility is now going to have to check that that is what I am going to do. We might be talking about a small day surgery that has one nurse who basically looks at all of this regulation and makes sure they are compliant. You might have five surgeons doing cosmetic surgery, and they now have to make sure those surgeons are assessing patients properly.

The facility is going to have to check that the surgeon's cosmetic surgical advertising is compliant with the national guidelines. That is in the draft document. That compliance with cosmetic surgery advertising is already required of us by Ahpra. Ahpra is already educating us and we already agree to it in our Ahpra code of conduct, so it is unnecessary duplication. The facility should not have to wear that burden when it is already happening elsewhere.

The facilities are going to have to collect psychological screening assessments of the patients undergoing cosmetic surgery. Again, that is something I do in my rooms with a patient. I assess their psychological suitability. If I have concerns I send them to a practitioner who is better able to assess that, but the facility is now going to have to make sure I am doing that for everyone having cosmetic surgery. We have concerns about the privacy and confidentiality of that. Does a hospital really need to know the intricate details of a patient's psychological health? We have concerns about how it would impact on the doctor-patient relationship if an administrative officer in a hospital is starting to talk to a patient about their psychological health.

Hospitals are going to have to ensure cooling-off periods are observed with consent processes. It is now very clearly defined within the national guidelines that cosmetic surgery patients need to have two separate consultations and there needs to be a cooling-off period of 10 days following that before surgery can be booked and consent forms can be signed. The facility will have to check that. We are already obliged as practitioners to do that.

There are other things. The facility is going to have to calculate the carbon credits of cosmetic surgery. I understand that is an important thing for the wider community, but it is not something that is currently required for any other form of surgery so why is it that cosmetic surgery needs to do that?

Mr J KELLY: Would it be an occurrence that you have surgeons who perform both reconstructive and cosmetic surgery?

Dr Won: Very commonly.

Mr J KELLY: So you are going to have two differing sets of regulations that you have to comply with, depending on the patient sitting in front of you.

Dr Won: I do already, but the facility is going to have to. We are duplicating something that exists already, that is standalone and not even running in parallel. If you compare the two documents, they do not even line up.

Mr J KELLY: For example, nurses and doctors are required to report suspected child abuse or sexual abuse. That is just the expectation of your profession. You are actually legally obliged to do it. As a practitioner you should know that. You are trained. This is the equivalent: the facilities would now need to go around and check that you are doing what you are already expected to do and legislatively required to do?

Dr Won: Correct, and someone has to pay for that. The government is not paying for that. The private facility is going to have to pay for that. They are going to have to pay for more staff to do that or they can make the decision, 'You know what? Those five facelifts we do a year: we can't be bothered. We are just not going to bother and we will not do cosmetic surgery anymore.'

Mr J KELLY: How could this legislation we are considering here today be amended or changed?

Dr Won: At the moment, cosmetic surgery is not part of the existing standards. That has been the problem, because it can be performed anywhere outside of accredited facilities and that is where the patient harm happens. The intent—to have regulation to force it to be done in a facility that is accredited—is great. Absolutely, it will add to patient safety, but all you need to do is take it and put it under the normal surgery standard. You do not need to create a whole different one. We are already making sure that taking out gallbladders and doing appendectomies is safe. We are just saying: take cosmetic surgery and put it under the same list of rules as any other operation and that will plug the gap that exists there. It does not really need to be any more complicated than that.

Ms DOOLEY: Thank you for being very articulate and clear. You can read that, but to hear you say it is much better so thank you. I have a question around the endorsement process. You indicated there were recommendations. Why do you think they have not been implemented?

Dr Won: Essentially, in Australia at the moment it is legal to perform cosmetic surgery even if you are not a surgeon. You do not have to have a surgical qualification to perform surgery in our country. Doctors who have completed their medical degree and completed one to two years of general registration as a junior doctor in a public hospital who obtain their general registration are allowed to go down to James Street, open up a clinic and start putting in breast implants.

Ms DOOLEY: That horrifies me.

Dr Won: It horrifies me too. As yet, the federal government has not plugged that hole. Instead what we are doing is plugging other holes and trying to make it harder for people who are not adequately qualified to perform surgery. By forcing cosmetic surgery to be done in accredited facilities, essentially what you are doing is making that facility the gatekeeper of who they allow to do the operation. If you go to a large private facility, say Greenslopes Private, that has a large number of practitioners on its books, it can be selective about who it lets perform surgery there. They will only choose the qualified practitioners; they will not choose people without the appropriate qualifications. There is inherent safety, if you like, in that larger centre. If you are talking about a smaller community-based facility where perhaps there is a corporate need to make money, they can allow people to work in their facility regardless of qualification. By bringing cosmetic surgery under accreditation of facility standards, you are making it harder for small facilities out in the community that are not appropriately accredited to do surgery. It is sort of a soft way of achieving the ultimate aim, which is making sure all surgery is performed by surgeons.

Ms BOLTON: When the amendments were drafted, obviously you were consulted.

Dr Won: Absolutely.

Ms BOLTON: And raised this duplication.

Dr Won: Absolutely.

Ms BOLTON: Can I ask what the response was when you raised it?

Dr Won: I would have to take that on notice. Essentially, I am not sure it was appropriate, in our view.

Mr LEE: Earlier in your presentation you talked about the definition of cosmetic surgery. Just for clarification, someone who is purely injecting botox—

Dr Won: That is not cosmetic surgery.

Mr LEE: It is defined as cutting into the skin.

Dr Won: Cutting beneath the true skin. It is well defined by Ahpra and the Medical Board, publicly available on the website. We are not talking about botox, filler, non-surgical injectables. They are not part of this legislation.

CHAIR: We are going to have to wrap up. If you have any other information that you would like to pass on to the committee, we would welcome that. I think there is one question on notice.

THEN, Professor Shih-Ning, School of Law, Queensland University of Technology; and Deputy Director, Australian Centre for Health Law Research

CHAIR: Welcome. Would you like to make an opening statement?

Prof. Then: I would like to thank the committee for the opportunity to speak. My comments this morning relate solely to the proposed amendments to Queensland's Transplantation and Anatomy Act. The proposed amendments to that act address an identified gap in decision-making at the end of life relating to deceased donation, particularly non-therapeutic interventions aimed at increasing the chances of success of donation after death. This gap was highlighted in a recent *Medical Journal of Australia* article that I co-authored so I am pleased that Queensland is addressing this and following New South Wales and Victoria to clarify the situation. However, it comes at a time of a national review by the Australian Law Reform Commission of all state and territory human tissue legislation, so I hope the Queensland Transplantation and Anatomy Act will be reviewed as a whole in the future with regard to national consistency based on the ALRC's future recommendations.

In relation to the current proposed amendments, I wanted to bring to the attention of the committee two issues. The first relates to potential conflict between substitute decision-makers for adults who lack decision-making capacity and the second relates to the need for guidance for those substitute decision-makers. The amendments introduce provisions which explicitly allow a substitute decision-maker to authorise ante-mortem interventions and blood tests to determine tissue type. In doing so, it follows the approach of New South Wales and recognises the senior available next of kin as the appropriate substitute decision-maker. The senior available next of kin is the person defined under the Transplantation and Anatomy Act who is able to authorise deceased donation in certain circumstances. However, during a person's lifetime, including at the end of life, substitute decision-makers are authorised under the Guardianship and Administration Act and the Powers of Attorney Act to make decisions on behalf of an adult who lacks decision-making capacity. While a senior available next of kin under the Transplantation and Anatomy Act and substitute decision-makers for end-of-life treatment under the other legislative schemes will usually be the same person, because they exist under different legislative schemes and different definitions apply that is not guaranteed.

This is an issue which has been highlighted in previous publications of mine. Again, I am happy to share that with the secretariat if wanted. This gives rise to the possibility that there will be two decision-makers at the end of a person's life and you could anticipate that there may be situations where conflict could arise. I recommend that a mechanism be added to the act to ensure there is a way to resolve any conflict that arises. I note that New South Wales has a provision that tries to resolve the relationship between their two acts.

The second issue is that these new provisions clarify who can make these decisions but offer no guidance as to how those decisions should be made. I suggest that it would be helpful for the legislation to provide guidance relating to how the decision should be made by the substitute decision-maker. There are a few possible approaches. I would suggest to consider making the decision that the person themselves would have wanted, so a substitute judgement approach, or potentially adopting an approach similar to how the donation decision is made after death, so the senior available next of kin could consent if there is no known prior objection by the person. Again, New South Wales has some guidance on this matter. Thank you.

Dr O'SHEA: Thank you very much for coming in. In that situation where you might have somebody who has power of attorney and then you have somebody who is viewed as the senior next of kin, how would you envisage that there could be amendment made to sort that out in very emotionally charged situations and often at two o'clock in the morning as well?

Prof. Then: Absolutely. When you have the situation where you have two different people appointed in these positions, there is not going to be an easy way to solve that. What I think we need in the legislation is legal clarity around who we look to now and what the law says. Certainly in New South Wales, the approach—I think it is under section 27F there—is that the senior available next of kin's consent will operate unless it is incompatible with a decision made by a substitute decision-maker at the end of life. That is one way they have clearly said, 'Your decision will apply unless this is operating.' That is one approach that can be used. I think that transition in decision-making authority at the end of life is a problematic one that the ALRC are aware of. I think ideally we would have no transition there and no conflict, but that is what we have at the moment.

Dr O'SHEA: If the view of the substitute decision-maker is different to the senior next of kin, is that then the defining opinion that is taken?

Prof. Then: Is this in New South Wales you are talking about?

Dr O'SHEA: Yes. How does that operate at the moment?

Prof. Then: I do not know clinically how it operates, but what the law provides for there is that the senior available next of kin's decision to consent, presumably to the ante-mortem intervention, will apply unless it is incompatible with a decision for treatment that the substitute decision-maker has made. You may well have a conflict and they go with the senior available next of kin authorising ante-mortem interventions. That is the resolution that their legislation has proposed.

Dr O'SHEA: Even if it is incompatible, they still go with the senior next of kin?

Prof. Then: If it is incompatible with treatment that has been authorised, they will go with the substitute decision-maker, yes. I am sorry, I did not express that well.

Dr O'SHEA: Could you explain decisions on end-of-life care with Gillick-competent children?

Prof. Then: In my submission I raised that children are treated the same as adults who lack decision-making capacity under the current proposed decisions. There is no distinction made between a child who is an infant and a child who may be 16 or 17 years old and has capacity themselves. In other medical contexts, if a child can reach a certain threshold of competence, known as Gillick competence, then we let them make their own decisions. Under the Transplantation and Anatomy Act generally, there is a variety of ways in which they acknowledge or do not acknowledge a child's competency. That perhaps extends beyond the proposed provisions here and, again, is probably an issue that the ALRC might make some global recommendations about. Certainly, if the committee wanted to take it into account, that distinction between an infant and a 16- or 17-year-old I think is quite significant. You could allow, within the proposed amendments, a child with capacity to make that decision themselves if they are able to.

Mr LEE: You mentioned the ALRC doing a review. Is there any idea on the timeline on that being completed?

Prof. Then: Yes. I should say that I am on the advisory committee for that review. I believe their discussion paper is due out in the next couple of weeks and they are due to report to the Attorney in the third quarter of next year.

Mr LEE: Is there any discussion around a nationally consistent approach?

Prof. Then: I think the review to the ALRC was with the agreement of all of the states and territories. That was some years in the making. The hope is that we will be moving towards some sort of national consistency legislatively. My understanding is that that is certainly what the sector wants.

Mr LEE: Looking at the New South Wales legislation, has that informed the process?

Prof. Then: The ALRC will be looking at all of the legislative approaches across the country. They all started from a similar recommendation by the ALRC in the 1970s and they have all deviated their own way, as things do in a federation, so the idea is to try to get back to harmonisation and consistency with that review.

CHAIR: In the interests of time, we need to wind things up. Do you have any written examples of conflict resolution?

Prof. Then: I certainly have some examples that can demonstrate where you have two different decision-makers at that point.

CHAIR: Would you be happy to provide us with some of those?

Prof. Then: Absolutely, yes.

CHAIR: Thank you. Thank you so much for your appearance today.

GALEA, Ms Michelle, Chair, ARTfam Australia/ASMBC (via videoconference)

SEGBEDZI, Ms Nandi, Secretary, ARTfam Australia/ASMBC (via videoconference)

CHAIR: Good morning. Would you like to make a brief opening statement?

Ms Segbedzi: Good morning. My name is Nandi Segbedzi. I am the secretary of ARTfam, which is the Assisted Reproductive Treatment Families Australia. I know it is a mouthful—I am very sorry. We also represent a sector of the ART families, which is the Australian Solo Mothers by Choice. Essentially, we are a relatively newly established body set up to provide support to our donor-conceived families and families undergoing ART. We also advocate for change and law reform and inform the general public about us as a group so that our children can grow up and thrive in the Australian community without the stigma that is sometimes attached to donor conception. With me is Michelle Galea, who is the founder and chair of our body.

Ms Galea: Thank you for having us today.

Ms Segbedzi: In terms of a statement, ARTfam was formed late last year after we essentially started the advocacy process in Victoria in relation to legislation changes there. We worked out that we were a group of individuals who were essentially trying to have our voices heard by government, and we thought it would be advisable to form an organisation to advocate on our behalf. We wanted to get all of the different groups in the donor conception and ART community together and provide government and clinics with a collective of lived experience so that those voices could be taken into account in their decision-making.

This year, of course, there have been quite a lot of reforms proposed and action as well as some very sad cases of people undergoing ART and then having difficulties. We have been involved in many of those cases and involved in many of those law reform processes. One of them, of course, was Queensland. I might hand over to Michelle so that she can explain what has happened in our community in relation to the Queensland changes.

Ms Galea: Thank you so much. When IVF treatments were cancelled overnight, a lot of our members were left quite devastated. They had been undergoing treatment for many years already. We are not just talking about a simple IVF procedure here; we are talking about people who have long-term infertility struggles. When you are told overnight that you cannot continue your treatment, it is quite devastating. These people were left distraught. They received an email telling them that their medical treatment could no longer continue, and that has left them broken. They had nowhere to turn, and that is why a lot of people sought us out and told us their stories. That is why we then contacted Queensland Health.

That is the other thing: they have no-one to call. They cannot even contact a government department to get any help on these sorts of issues. We pushed it. We pushed you guys, obviously, and we welcome these changes. To be told overnight that you cannot use your embryos or you cannot have an egg collection tomorrow and have the eggs fertilised with the sperm that you had purchased when this is your last chance to be able to have a child that is genetically related to you is devastating. I had women crying on the phone. They were just devastated and broken.

We have women who have been trying for many years to have their first child or to increase their family by having siblings for their children. It was distressing. It was heartbreaking. A lot of these women are still very scarred by the process of what happened to them, even though they can continue. Obviously we are thankful for the grandfathering period and also for the approval on a case-by-case basis that you are bringing in.

We were listening to the committee hearing earlier, and one of you asked how donors were traced. Yes, you have a 10-family limit in Queensland. Victoria has a 10-family limit. New South Wales has a 10-family limit. How do we know that these donors are not going interstate? That is a really good question, because that is happening. Donors are donating to multiple clinics and they are also doing private donations. We have some donors, whom we like to call serial donors, who want to repopulate the earth, which is great in one way but not great for the donor-conceived children. This is why we are calling for a national framework donor register—so clinics and states can talk to each other and if a donor wants to donate they can check that they have not donated in every state. This is where we are seeing families exceeding the 10- and five-family limits.

Some governments believe it is not really an issue, but when 16 per cent of the population, and growing, are infertile, when donor gametes are increasing and when the solo mother community is also increasing at a rapid rate—we say that one in six children now are born through IVF—we really need to get it under control and put some regulations in place so we cannot have families exceeding

the limits. Some people say, 'You'll never connect. People won't connect.' It has happened quite a lot in our group. We have had a family picnic or a Christmas party and people have looked at their children and looked at other children and said, 'Our children look alike. Shall we swap donor numbers?' and then they have found out that they have used the same donor.

I have one family here who met like that at a picnic and then they realised that they were in the same hospital nursery on the same night when the children were born. They were born within a couple of days of each other. We have also had families find out that another donor sibling lives in the same street. The donor children are connecting. It is not as scarce as some believe it is. If the donor registers are not kept properly and the donor children do not know that they are donor-conceived—if their parents do not tell them—then there is the chance that they could marry and reproduce with a sibling.

Ms DOOLEY: Thank you for your presentation. Your submission did note some concerns about the proposed drafting of section 39B. Can you elaborate on your concerns?

Ms Segbedzi: Essentially, this is part of the case-by-case mechanism. We are very grateful that that has been put in place. Essentially, the IVF provider will make an application to the director-general for permission to use an embryo or a gamete in circumstances where the legislation would otherwise prohibit it. In order to make that application, firstly the IVF provider must contact the gamete donor—who is usually a sperm donor but sometimes they can be an egg donor—and get their consent to make the application to the director-general. The donors have usually given consent to, for example, their gametes being used up to the 10-family limit or used within a certain timeframe. That is one set of consents which is obtained well before the gamete is allocated.

Here there is the opportunity for the gamete donor to consent, or otherwise, merely to the application being made to the director-general. We have had an experience in Victoria where the donor had consented to their gametes being used once or twice in a family, and when the recipient came back for the third time to use her embryos which had been created using the donor gametes the gamete provider refused. If that situation happened in Queensland, we would not necessarily know the reasons for that refusal. They could simply refuse the application being made to the director-general. In that situation we understand—or we suspect—that the reason the gamete donor refused her gametes being used a third time was that she disapproved of the age of the recipient.

If they were merely asked to consent to an application being made, we would not necessarily know anything about their reasons for refusing. They could just refuse. At that point, the application would be dead in the water. It would not make it to the director-general because the director-general must be satisfied that the donor has consented to the making of the application. It is possible then that the rules or the laws around preventing discrimination by donors of recipients could be circumvented because all they would be doing is refusing the application rather than refusing the use of the donor gamete. That is a bit of a concern because we have already had a situation in which that could potentially be exploited.

We have a view about donors. Sometimes they are purely altruistic and simply doing it out of the goodness of their hearts, but they are also human and sometimes they have reasons for doing things that may not stand up to perhaps moral scrutiny. There are donors, for example, as Michelle has already mentioned, who are simply there to spread their seed. It is unfortunate, but they do exist and they are a problem in themselves. Then there are the donors who are quite reluctant to give their gametes, for example, to single women or to queer, lesbian and gay couples for reasons that relate to their own personal morality. At the moment, it would be possible for that personal morality and those personal decisions to influence the making of an application to the director-general for permission to use those gametes.

We think this could be avoided if, rather than requesting the donor to consent to the application, the donor is simply made aware of the application, to provide them with notice that it is going on. There is still the possibility that they can look at the consents they have already given in the past and say, 'My mind has changed,' in which case the director-general can engage in contact with that donor or discussions with the IVF provider and the recipient. Then the director-general can make their decision objectively using the criteria in the legislation, which is essentially that they want to avoid hardship to any person involved.

CHAIR: I need to pull you up because we are running out of time. I am conscious there might be some other questions so we need a bit of brevity.

Ms Segbedzi: Yes, of course. It is simply to make sure that the decision is in the hands of the director-general.

Ms BOLTON: Recognising time, could you take this question on notice? Do you have access, via either experience or data, to the percentage of people who are currently using private donors? A national register was brought up at the last inquiry. Is there any progress on that?

Ms Segbedzi: We do not have any data on the number of families using private donors. Generally, private donors may be what is called 'known donors'. They are people who may have volunteered to assist a family. That tends to be something which occurs in the LGBTQ community perhaps more than others. If it happens in heterosexual families it is usually a relative, but it does not happen a great deal in our community—that is, solo mothers. We tend to rely on clinic donors, so they are anonymous—at least at the time of donation.

Ms Galea: There is actually an increase in the unregulated donor space—women using unregulated donors. We are talking about a donor who is not known to them. They have found them on a Facebook page, for example. We are quite concerned about this. This is where a national register—of anyone using a known donor, a clinic donor or an unregulated donor—would be helpful. We are also getting a lot of women who are getting groomed in the unregulated donor space. The reports we are getting are quite problematic and scary, so it needs to be addressed.

CHAIR: Thank you. Our time has expired. Thank you for joining us today.

BRODNIK, Ms Kate, Principal Policy Solicitor, Queensland Law Society

DEVINE, Ms Wendy, Manager, Legal Policy, Queensland Law Society

TATE, Mr Rohan, Member, Industrial Law Committee, Queensland Law Society

CHAIR: Welcome. I invite you to make a brief opening statement.

Ms Devine: Thank you for inviting the Queensland Law Society to appear today. In opening, I would like to respectfully recognise the traditional owners of the land on which we are meeting. As the committee may be aware, the Queensland Law Society is the peak professional body for the state's legal practitioners. We are an independent, apolitical representative body.

You will see from our written submission that our substantive comments relate to the amendments to the Hospital and Health Boards Act and other legislation regarding the processes for the removal of board members and the amendments regarding the CEO for Health and Wellbeing Queensland and the Queensland Pharmacy Business Ownership Council. The amendments allow a board member or CEO to be removed from their position without grounds. This is inherently unfair and lacking in transparency, denying those impacted any meaningful natural justice and procedural fairness. This new process risks creating psychosocial hazards for the impacted individuals. In its briefing to this committee, the department indicated—

The broadened removal powers in the Bill will enable the Governor in Council to act swiftly on the rare occasions where the Government or the public have lost confidence in an office holder.

However, the bill as drafted does not refer to extraordinary or rare circumstances. The bill also does not reflect the explanatory notes, which suggest that natural justice would ordinarily be observed when exercising these powers, including giving an affected person notice of a proposed action and an opportunity to be heard.

Our submission outlines several proposed amendments to the bill that will lessen the adverse effects of these broadened powers while still allowing for change to deal with the issues outlined by the department about timeframes under the current processes. However, we would also support broader reform. QLS supports the timely progress of the revised Welcome Aboard materials and appointment guidelines published by the Department of the Premier and Cabinet to ensure office holders are appropriately appointed and candidates are managed pursuant to a clear evaluation process prior to appointment and renewal. We also suggest preparation of specific guidance around processes for removal of office holders.

Robust appointment and other processes would likely address some of the concerns raised in the explanatory materials while ensuring an individual's fundamental rights are protected. Transparency in these processes will promote public confidence in the roles and in government's decision-making. This would also help attract good candidates to these very important positions.

I am joined today by Rohan Tate, a member of the QLS Industrial Law Committee, and by Kate Brodnik, QLS principal policy solicitor. We welcome any questions the committee may have.

CHAIR: We had a brief provided to us by the library today which demonstrates clearly that there is significant precedence for this particular clause. In fact, there were more than 30 other examples. I wonder if this is an issue you have raised concerns about previously, because it seems to be common practice to have a fairly broad clause on this matter.

Ms Devine: We understand from the explanatory notes that this proposed change is not unusual and it does appear in other legislation. It may be that the library has identified some additional legislation to what is in the explanatory notes. We would suggest that simply because it has been written in the past does not mean that we should not reconsider it. Each time legislation is introduced is an opportunity to consider it, to scrutinise it again and to assess whether it is meeting the needs of these boards and the community. There are multiple boards affected by this legislation. We also note it has some retrospective effect because it affects those who are already in positions. The fact that it has been written before does not mean that we should not perhaps call it out now and check whether that is really the best way forward.

CHAIR: Has the Law Society ever raised concerns about this in the past, given that there is an enormous amount of precedent for this particular clause?

Ms Devine: I am not aware of whether we have done that, I am sorry. I cannot answer that.

Ms Brodnik: I do not know whether or not we have commented on the processes as they apply to particular boards. It depends on when those provisions were inserted and amended and whether or not QLS was in a position to comment at that time. However, we do routinely advocate for robust procedural fairness and natural justice provisions in myriad other legislation.

Mr J KELLY: It would be the QLS position that these provisions should be removed from all bills going forward? Is that fair to say?

Ms Devine: Our position is that we recognise government needs some flexibility and that there are circumstances that arise—they were described as 'rare' by the department—where the ability to act quickly is needed. Our concern is that the explanatory notes suggest natural justice would be afforded. In reviewing the Hospital and Health Boards Act's guidance material for board appointments, that process is not reflected with respect to removal.

As we flagged in our submission, if this legislation proceeds in its current form then we would recommend that, at the very least, those documents be updated to reflect natural justice procedures. That would mean that those who take on these positions understand the process that is likely to apply to them in the event that something needs to happen.

We also flag that the advantage of a natural justice process and the opportunity to be heard by the person affected can often give rise to further facts or to a better understanding of their position and what the particular situation is. That opportunity to be heard is really important to make sure that all of the facts are understood before a final decision is made, because removal from a board does affect someone's reputation and does affect their potential to be reappointed in similar positions in the future.

Mr J KELLY: Is the mischief we are protecting against here—by allowing someone to effectively remove somebody with no public statement or private statement that attests to the reasons for that removal—that you could not rule out that that removal was done for reasons of political decision-making or personal vendettas and may not be related to the person's performance?

CHAIR: We might be veering into matters of opinion.

Mr J KELLY: It is a fair question, Chair. I am asking: can you rule those things out if there are no decisions published or made publicly available?

Ms Devine: The provisions as drafted allow for removal with no reason. How that is applied and what would be published would be a decision for government at the time.

Mr J KELLY: In terms of the practice of removing someone in any kind of workplace setting—let's broaden it from boards—it is common in industrial relations now that if an employee poses a risk to an organisation they can be removed immediately but still have procedural fairness applied. Is that a fair and correct statement?

Mr Tate: That is how it should be done. Certainly, if you have a common law contract and an employee then usually, particularly for senior employees—CEOs I think you would consider by some of these amendments—there would be a capacity to stand down, put someone effectively on gardening leave, while an investigation occurs and findings can be made.

Mr J KELLY: Did you make a submission to the major sporting facilities legislation, where this exact provision was removed by the government? It was stated by the minister in the first reading speech that it was removed for reasons of being 'for governance'.

Ms Brodnik: No, we did not make a submission.

Mr LEE: In your submission you talked about some sort of exceptional circumstances clause. What might that look like?

Ms Devine: We have not turned our mind to specific drafting, but we note that, for example, in the hospital and health boards provisions there is the power to suspend a board member if there is a concern around their conduct. I believe that provision refers to the concept of public interest. That is certainly a test that we see in many other statutory provisions about exercising powers like this or, indeed, in making decisions generally around releasing information, for example in right to information legislation. That public interest test is fairly well understood, I would suggest, by government officers and decision-makers and by lawyers as well. That is perhaps something that could be considered.

Mr LEE: The department, in response to your submission, made the observation that procedural fairness and natural justice is already part of our common law and there is no need for an express provision to that effect. What do you have to say to that?

Mr Tate: I am not certain that it is an implied term at law in an employment contract to give efficacy to the contract. It is true that there are certain statutory provisions in terms of unfair dismissal et cetera which does require procedural fairness and those sorts of things. It may be that a common law contract of employment might have a contractual right. It may be that there is a policy framework which might suggest that those things happen. I am not certain that I quite agree that a right at large exists, but it is usually something that is found somewhere—in an industrial instrument, a common law contract or perhaps a statutory framework like an unfair dismissal regime. I think guarding it is important.

CHAIR: Given the concerns you have raised, are you aware of any precedent where these powers have been used unfairly? Have you had complaints or are you aware of any occasions when people have been removed and it has been brought to the attention of the Law Society?

Ms Devine: I am not aware of any.

Mr Tate: I am not aware of any either.

Ms BOLTON: Are the existing provisions for removal flexible enough to ensure underperforming board members can be removed? In essence, why would we need to have this amendment?

Ms Devine: I believe each of the acts that are being amended do contemplate the power to remove—for example, if a person has become insolvent. They do vary a little across each of those provisions. I would like to take that question on notice, because I know there is some variation across each of those.

Ms Brodnik: The suspension provisions that Wendy mentioned do set out indicia that may be used as a guide. If it was determined by the department that those same parameters were needed for removal, not just suspension, then that is something that could be looked at. In that case, that would ordinarily require something to be established, put to the individual to respond to, and hopefully create the normal system that is akin to a show cause process.

CHAIR: Thank you. We are out of time, unfortunately. That concludes this public hearing. Thank you to everyone who has appeared and participated today. Thank you to the Hansard reporters. A transcript of proceedings will be available on the committee's webpage in due course. There have been some questions placed on notice today. Responses are required by Wednesday, 26 November. I declare this public hearing closed.

The committee adjourned at 11.01 am.