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HEALTH, COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE

Members present:
Mr AD Harper MP (Chair)
Mr MC Berkman MP
Mr MA Hunt MP
Mr MF McArdle MP
Mr BL O'Rourke MP
Ms JE Pease MP

Staff present:
Mr R Hansen (Committee Secretary)
Mr J Gilchrist (Assistant Committee Secretary)

PUBLIC BRIEFING—INQUIRY INTO THE HEALTH AND OTHER LEGISLATION AMENDMENT BILL 2018

TRANSCRIPT OF PROCEEDINGS

PROOF

WEDNESDAY, 5 DECEMBER 2018

Brisbane

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The committee met at 12.59 pm.

CHAIR: Good afternoon, ladies and gentlemen. Thank you all for being here today. Before I start, I ask that all mobile phones be switched off or to silent. I now declare this public briefing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee open. I would like to start by acknowledging the traditional owners of the land on which we are meeting today. I am Aaron Harper, the chair of the committee and member for Thuringowa. The other members of the committee are Mr Mark McArdle, member for Caloundra and our deputy chair; Mr Michael Berkman, member for Maiwar; Mr Marty Hunt, member for Nicklin; Mr Barry O'Rourke, member for Rockhampton; and Ms Joan Pease, member for Lytton, who will be joining us very shortly.

The Health and Other Legislation Amendment Bill 2018 was introduced on 13 November 2018 by the Hon. Dr Steven Miles MP, Minister for Health and Minister for Ambulance Services. The committee is required to report on the bill by 14 February 2019. The purpose of this session is to receive a briefing from officers from the Department of Health to assist us in our examination of the bill. Many departments will be represented here as we go through various parts of this bill.

There are a couple of procedural matters before we start. The committee is a statutory committee of the Queensland parliament and as such represents the parliament. It is an all-party committee which takes a nonpartisan approach to our inquiries. This briefing is a formal proceeding of the parliament and will be subject to the Legislative Assembly's standing rules and orders. The committee will not require evidence to be given under oath, but I remind you that intentionally misleading the committee is a serious offence. Witnesses have been provided with a copy of the instructions for witnesses so we will take those as read. Hansard will record the proceedings and you will be provided with a copy of the transcript. This briefing will also be broadcast live on the parliament's website.

For any media present, I ask that you adhere to my directions as chair at all times. The media rules endorsed by the committee are available from committee staff if required. I remind those in attendance today that these proceedings are similar to parliament to the extent that the public cannot participate. I remind members of the public that they may be admitted to, or excluded from, the briefing at the committee's discretion. Please also note that this is a public briefing and you may be filmed or photographed. Today we will hear primarily from officers of the Department of Health as well as officers from the Department of Housing and Public Works, depending on the issues raised.

BALLANTYNE, Dr Sue, Senior Medical Adviser, Prevention Division, Department of Health

BENNETT, Dr Sonya, Acting Chief Health Officer and Deputy Director-General, Prevention Division, Department of Health

LAW, Ms Kirsten, Director, Legislative Policy Unit, Strategy, Policy and Planning Division, Department of Health

MATTHIAS, Ms Tricia, Manager, Legislative Policy Unit, Strategy, Policy and Planning Division, Department of Health

SAMMON, Mr Damian, Director, Legislation and Reform, Department of Housing and Public Works

WALL, Mr Mark, General Manager, Department of Housing and Public Works

CHAIR: Dr Bennett, I thank you and your colleagues for attending today. Before you make an opening statement on the bill and we move to questions, I welcome members of the public. It is fantastic that people are interested in what is going on. This bill will repeal the Public Health (Medicinal Cannabis) Act 2016; establish a Notifiable Dust Lung Disease Register; and amend the Radiation

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Safety Act, the Transplantation and Anatomy Act, the Births, Deaths and Marriages Registration Act, the Coroners Act and the Retirement Villages Act. It is what we call an omnibus bill. It has a number of moving parts to it. We do appreciate your time and that of the representatives from the various departments and for better informing us as a committee as we progress through the bill. Dr Bennett, would you like to make an opening statement on the bill before we move to questions?

Dr Bennett: Thank you for the opportunity to brief the committee today about the Health and Other Legislation Amendment Bill 2018. I am the Chief Health Officer and Acting Deputy Director-General for Prevention Division in Queensland Health. I am joined by Ms Kirsten Law, the Director of the Legislative Policy Unit of Queensland Health and Ms Tricia Matthias, the Manager of the Legislative Policy Unit of Queensland Health.

As you have said, given that the bill covers a wide range of matters we may call on other officers from Queensland Health and the Department of Housing and Public Works in relation to particular issues if required. These officers are Dr Sue Ballantyne, the Chief Medical Officer of the Healthcare Regulation Branch in Queensland Health; Mr Mark Wall, General Manager, Department of Housing and Public Works; and Mr Damian Sammon, Director of Legislation and Reform, Department of Housing and Public Works.

The bill amends several Health portfolio acts and a number of acts outside of the Health portfolio. The bill is supported by the draft Health Legislation Amendment Regulation 2018, which the minister tabled in parliament when introducing the bill. The committee requested additional material from the department about the bill and the policy drivers behind it. The director-general has provided the committee with this material. I propose to provide a short summary of the bill for the committee's benefit forthwith, starting with amendment to the health acts.

The bill will repeal the Public Health (Medicinal Cannabis) Act 2016 and amend the Health Act 1937 to ensure that medicinal cannabis can be regulated under the Health (Drugs and Poisons) Regulation 1996. These amendments will enable medicinal cannabis to be regulated under the same Queensland legislation as other scheduled medicines. The proposed changes to the Health (Drugs and Poisons) Regulation to support this policy are set out in the draft amendment regulation.

The bill also gives effect to recommendations made by the Coal Workers' Pneumoconiosis Select Committee of the Queensland parliament in its *Black lung white lies* report by establishing a Notifiable Dust Lung Disease Register. The draft amendment regulation will amend the Public Health Regulation to require certain medical practitioners to notify Queensland Health when they diagnose specific lung diseases related to occupational inorganic dust exposure in any industry. This will include cases of silicosis that result from occupational exposure to manufactured stone benchtops.

The bill will amend the Public Health Act to enable the chief executive of Queensland Health to direct a person responsible for a pollution event to publish a public notice about the health risks of such an event. Queensland Health will be able to direct both the content of the pollution notice and what form it takes to ensure impacted communities are properly informed. It will be an offence to not issue the notice when directed by the chief executive, with the maximum penalty of 200 penalty units.

The bill will also amend the Radiation Safety Act 1999 to enable certain persons to be prescribed in the Radiation Safety Regulation as use or transport licensees for certain low-risk activities. The draft amendment regulation provides that dentists using some types of dental X-ray equipment are prescribed licensees. It also provides that a person transporting a radioactive substance into Queensland is a prescribed licensee if they have authority in another jurisdiction. These prescribed licensees will still be subject to the same requirements, standard conditions and penalties for contravention as other licence holders.

The bill makes several amendments to the Transplantation and Anatomy Act 1979. It will clarify the provisions around clinical research where it involves removing tissue from adults and children. It will also ensure pathology laboratories can access the necessary tissue based products for diagnostic and quality control purposes, and it will remove the restriction for a post-mortem examination of a body conducted in a hospital to only be held in a hospital mortuary.

Under the justice portfolio legislation, the bill amends the Coroners Act 2003, Cremations Act 2003 and Births, Deaths and Marriages Registration Act 2003, which are administered by the Attorney-General and Minister for Justice. The Cremations Act requires that an independent doctor issue an approval before a human body or part is cremated. Before issuing the approval, the doctor must consider the cause of death certificate for the body. The Coroners Act prohibits the cremation or burial of a body or part unless a cause of death certificate has been issued. Because of the nature of the work undertaken by schools of anatomy, it can be difficult for a doctor to issue an approval matched with a cause of death certificate for each individual body part following dissection. The

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amendment will alleviate the practical burden on doctors and schools. Schools of anatomy will continue to respectfully dispose of donor body parts used at a school of anatomy for the study and practice of anatomy.

Finally, the bill will amend the Retirement Villages Act 1999 to clarify recent reforms to that act. These amendments extend recent reforms to ensure that residents are paid their exit entitlements in a timely manner to freehold units as well as leasehold and licensed tenured units. This also requires a consequential amendment to the Duties Act 2001. As I have noted, I am joined by colleagues from the Department of Housing and Public Works who will respond to any questions on these amendments. I am happy to take any questions from the committee or direct the question to the relevant departmental officer.

CHAIR: Thank you very much for your opening statement. There are a number of moving parts to this. In regard to the amendment to the medicinal cannabis act 2016, does it make it easier for patients to access medicinal cannabis?

Dr Bennett: Correct. The intent of the amendment is to streamline the process for both doctors and patients—for doctors to prescribe medicinal cannabis for appropriate patients and for patients to access that care.

CHAIR: How does it better streamline the process? I thought there was a Commonwealth approval process as well as the state approval process. I think for members of the public it might be useful to explain how it better streamlines that process.

Dr Bennett: I will hand over to my colleague Ms Law.

Ms Law: The bill will repeal the medicinal cannabis act, which set up a separate framework for regulating medicinal cannabis. Currently, medical practitioners need to navigate two legislative frameworks when they are prescribing different medicines. This will put all of the regulation under a single regulation, the Health (Drugs and Poisons) Regulation.

There are a couple of changes. Once the act is repealed, specialist medical practitioners will be able to prescribe medicinal cannabis for any medical condition. Currently, under the medicinal cannabis regulation specialists can prescribe medicinal cannabis for particular patients—that is, patients with chemotherapy induced nausea or vomiting, terminally ill persons, children with drug resistant epilepsy, persons with multiple sclerosis and persons experiencing chronic non-cancer pain. Once the act is repealed, specialists will be able to prescribe any medicinal cannabis product for any condition they consider would benefit.

CHAIR: How many specialist medical practitioners are currently able to prescribe medicinal cannabis? It sounds like this bill might make it easier for the general public to access it.

Dr Bennett: I might ask Dr Ballantyne to provide the details. As I understand the question, it is those specialists who can prescribe now and how that will change.

Dr Ballantyne: With the repeal of the bill any medical specialist—and that includes specialist general practitioners and members of the rural and remote college, so ACRRM specialists as well as any other specialist—will be able to prescribe medicinal cannabis for any patient they consider it suitable for. The only people who will not be able to prescribe would be, for instance, a medical officer perhaps within a hospital who has not yet undertaken any type of speciality training.

CHAIR: So there is training to undertake?

Dr Ballantyne: Registrars in any of the specialities. We are talking orthopaedics, general medicine, respiratory medicine—any of the specialities that are included within the AHPRA website will be included in the repeal to be able to prescribe and most definitely specialist general practitioners who have the FRACGP.

CHAIR: I think that should give members of the public observing this some confidence that this will be an easier process. If the bill is passed in parliament, how long will it be before members of the medical fraternity are able to do this? What is the normal time frame to enact the legislation?

Ms Law: Those provisions of the bill will commence on proclamation so it will depend. There are amendments to the Health (Drugs and Poisons) Regulation that will need to be made to support the policy before the medicinal cannabis act can be repealed. I do not have a date, but once that regulation is made the bill repeal will come into effect then.

CHAIR: We know there is great interest from Queenslanders to make the process easier to access. Thank you very much for that considered response. In terms of notifiable lung diseases, you mentioned silicosis. How many cases have been reported to date? I know that there was an action from government to stop the number of grinding and cutting procedures they do in that industry. How many cases are you aware of at the moment?

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Dr Bennett: The intent of establishing the dust register is so we can answer that question specifically. We cannot answer it right now. The reason that the dust register was expanded from the initial recommendation was that there was recently some health surveillance of stonemasons and it identified 12 cases among 35 workers, which indicated that there was a problem.

CHAIR: I am not familiar with the Radiation Safety Act and the transportation of radioactive substances, but that is an interesting space. You mentioned dentists. To assist the committee to become better informed, can you unpack what that means to Queenslanders out there on the road? Is there some licensing? We are not across this particular issue.

Dr Bennett: I will answer that question about the training required for persons to be a prescribed licensee, so it will cover both the use and the transport licences. The qualifications required for a licence under the act vary according to the type of activity and radiation source. The act provides that, when deciding whether to issue a licence, the chief executive of Queensland Health may have regard to the qualifications, training, skills, knowledge and experience of applicants for use licences. In that instance, that involves dentists performing intraoral dental plane radiography, which is the most common type of dental X-ray equipment.

To be registered as a dentist under the health practitioner regulation national law, a person must hold a qualification approved by the Dental Board. There are more than 40 courses currently approved. These courses include radiographic training to provide dentists with necessary knowledge and skills to assess the risk of radiation exposure against clinical need and perform the necessary imaging to undertake radiological assessment of images.

The second part of that is for transport licence applicants. The act provides that, in deciding whether to issue a licence, the CE has regard to their competency in relation to their handling, packing, transportation, storage and delivery of radioactive substances. Queensland Health has determined that the qualifications for professional registration as a dentist also satisfactorily assess the requirements for transport licences. The second category will be transport workers who transport radioactive substances into Queensland to complete a delivery if they hold an equivalent authority in another jurisdiction.

CHAIR: Was there consultation with the Transport Workers Union on this proposed amendment?

Dr Bennett: Yes. There was wide consultation on all of the bill amendments. Specifically for changes to this particular area, it required consultation with the Radiation Advisory Council—in the first instance, it was necessary to consult with them—and the Queensland branch of the Australian Dental Association and the Transport Workers Union. They were all consulted on the amendments.

CHAIR: Thank you. I am just going through the points as you raised them and then we will move to other questions. In relation to the transplant amendments, my question again would be around consultation. You alluded to the fact that there would be benefits from undergoing some investigation of deceased persons in other parts of the hospital, rather than the mortuary itself—as in CT scanning. What are those benefits?

Dr Bennett: That is correct. The amendments in the bill take consideration of the fact that post-mortem examinations in hospitals at the moment are restricted to mortuaries. In the event of an autopsy, the use of any imaging, like X-rays or CT scans, is practically very difficult. It places a significant limitation on the form that a post-mortem can take, and it fails to reflect contemporary approaches to most post-mortem examinations.

Post-mortem examinations can yield important medical knowledge, particularly in relation to new or unusual conditions and the efficacy of new treatments. The use of imaging technology can reduce the need for invasive procedures at a post-mortem examination—for example, by facilitating a guided needle biopsy. It could increase the likelihood of consent by next of kin who may be concerned about the disfigurement of the body of a loved one. It adds another element to post-mortem examination by allowing them to take place outside the mortuary.

CHAIR: I imagine there would be some other benefits for criminal cases, and I am sure the former police officer who is a member of the committee will pick up on this. They could actually view injuries sustained and this would be better under a CT scan or through those investigative X-rays. I imagine there would be flow-on benefits through to the Police Service.

Dr Bennett: Yes. It makes a post-mortem examination more efficient by allowing imaging as well as just dissection and it potentially could reveal things that may be missed.

CHAIR: I will move on to the Cremations Act. I think it was the John Tonge Centre where I did some training in the Ambulance, and there was another one at Herston that I cannot remember the name of. It was interesting because people do leave body parts to science for clinical research and it

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provides significant advantages in the medical field. I was not aware that you would have to go back through to get a certificate of death. That seems quite cumbersome if the family has already made a decision to leave the body for clinical research. I think that is a very good, common-sense amendment to move. That is a comment only. It seems to be practical.

I am really interested in the retirement area. Can you better unpack the exit entitlements as they stand? We do talk quite considerably with those in aged care. We have Carlyle Gardens in Townsville which is huge. There is a significant investment by retirees into these places, but there seems to be a delay in accessing funds from a sale. Can you better interpret the amendment for me?

Mr Wall: I can run through an overview very quickly if that is suitable for the committee.

CHAIR: Yes, please.

Mr Wall: These amendments to the Retirement Villages Act will ensure that reforms that are to protect the retirement village residents apply to owners of freehold units as well as residents with lease or licence tenure over the village unit. On 10 November, the Retirement Villages Act was amended to require that departed residents must get their exit entitlement—that is, the money left over after the operator's exit fee is paid—no later than 18 months after they leave. That is currently within the legislation.

After the amendments were passed, industry representatives raised with the department their view that the drafting of the amendments did not apply this new protection to residents with freehold units. This is because, legally, owners of freehold units are not paid an exit entitlement by the operator but instead get paid an equivalent amount of money for selling their unit to a new incoming resident. This view was shared by the residents and the association of residents of retirement villages who have asked for equal protection, not only for the people on leasehold but also for the people on freehold.

The department register indicates the total number of retirement village units is 29,364. Of these, 2,201 are freehold, or about 7.4 per cent of the total number of units. The total number of villages is 319 across Queensland, of which only 22 have these freehold units, which is about 6.8 per cent of the villages.

The intent of the buyback amendments is to reflect as much as possible the original policy intent, which would apply to all tenure types and put all residents on an equal footing, whether you entered under a freehold arrangement or under leasehold. That means that the amendments will have their first payment date for unsold units on the same day as all the other tenure types, being 10 May 2019, which is 18 months from the original date of the assent of the amendments, depending on the bill being passed. This process is different to reflect the difference in the processes applying to each tenure. The end result is the delivery of the policy for the same impact for all tenants. It really is just trying to bring it all back into line. If you have had a unit and you are trying to sell it, and if it cannot be sold within 18 months, then there is a process for residential village unit holders to be able to receive their funds.

CHAIR: That is a good explanation. I do meet with retirees, who I find have a lot of time on their hands to become frustrated with the system. We engage with them quite regularly. I think that is a common-sense amendment and thank you very much for that explanation. We will move to other questions from the committee.

Mr BERKMAN: Thank you all for being here. It is a bigger crowd than we are used to at most hearings. I have a couple of quick questions about the amendments on medicinal cannabis. As I understand the proposed amendments, they really only change the framework for the prescription of medicinal cannabis products. I will take a step back. As I understand it, there are major barriers in terms of actually accessing products for people who are receiving these treatments and then there is the process for prescription. This only deals with the latter of those two. Is that right?

Dr Bennett: That is correct.

Mr BERKMAN: Any remaining impediments around the production or importation of any of these medicines are yet to be dealt with in other legislation?

Dr Bennett: That is correct.

Mr BERKMAN: I am curious about the existing arrangements for leased or licensed properties—that is, the retirement villages amendments. Can you outline for us in broad terms the existing framework that will be adopted for freehold properties? What happens for disputes about valuation? How are the exit fees calculated? Is that purely dependent on the agreements in each circumstance? Is there a framework around that?

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Mr Wall: I might get Damian Sammon to answer that.

Mr Sammon: Before this bill was introduced, there were amendments made last year in housing legislation to change the Retirement Villages Act to provide a mandatory payment of the residents' exit entitlement upon the point of 18 months after the departure. The exit entitlement is what the resident takes out of the village after they move out. To move into a village, residents pay an entry fee and other fees and charges. They live in the village, and the exit entitlement is paid out of the sale proceeds. The operator gets their exit fee, which is the money that the operator makes for running the village. There would be other fees and charges that are imposed upon the point of sale, but they are the basic concepts that we are dealing with in this amendment to the Retirement Villages Act.

The department was advised by resident stakeholders that sometimes it would take a long time for a retirement village unit to sell, to change hands. It could be many, many months or sometimes even years. For as long as the unit remains unsold, the resident does not get their exit entitlement so they do not get the return of their capital until the unit is sold. The amendments made to the Retirement Villages Act last year established that system for retirement village units that are generally under lease or licence arrangements. These amendments in the Health and Other Legislation Amendment Bill will extend that to apply to that relatively smaller amount of units—about 7½ per cent of units—that are held under freehold title.

Mr BERKMAN: I assume there will be fairly substantial differences for freehold units. Obviously, the owner of the unit has a more fulsome ownership under freehold than they would under lease or licence agreements. Imposing a requirement then for the retirement village to purchase back from the owner will necessarily involve some kind of agreement about the value of the property.

Mr Sammon: Yes.

Mr BERKMAN: What proposed arrangements are there for ascertaining that value?

Mr Sammon: By and large, what this bill before the committee does is try to replicate what was in the housing legislation amendment act last year and apply that policy to freehold units. In terms of the valuation of the unit, there is already a process in the act whereby residents and the operators seek to agree the value of the unit. If they cannot agree over a period of three months, then the operator can get a valuation of the unit and then that is the agreed price. That is how the price is set. It is not the situation where one person can establish a price in opposition to the other person. The operator cannot necessarily establish a price that the resident disagrees with. The resident and the operator have to agree. If they do not agree, there is a process already set out in the act to identify a price through the engagement of a valuer. That will then be the price for the unit when it comes to be assessed for mandatory buyback under these amendments. Largely, as I said, it is a process of replicating what is already in the legislation and applying that to that number of freehold units.

CHAIR: The member for Rockhampton, with his considerable experience as a former regional director of housing, is next, and I think I know where this question might be going.

Mr O'ROURKE: Michael pinched half of my question. I know that freehold issue has been a major concern for residents around Queensland. This is more of a comment in congratulating the Department of Housing and Public Works on the great work they have done around protecting the rights of those residents who are in freehold properties. That is more of a comment than anything else.

CHAIR: That is a good, common-sense approach by the department, I think.

Mr HUNT: I will stick with this theme while we are on it. Most of my questions have been asked and answered as well. It has been operating now since 2017, as I understand. Have there been any adverse impacts of this? Obviously, there would have been submissions made at the time this legislation was brought in by the operators, I would imagine primarily against this being imposed upon them. Have any of the suggestions they made in their submissions come to fruition, or have there been any adverse effects of this legislation?

Mr Sammon: We met with industry and resident stakeholders when developing the housing legislation amendments last year, and more recently we met with industry members about these amendments that apply to freehold villages. It is fair to say that the explanatory notes outline what the industry and resident concerns are about these amendments. It really will be a matter, I would respectfully submit, for those stakeholders to raise their particular concerns before the committee. Because there has been no requirement to make any payout yet, it is also appropriate to say that the impact of those amendments will not fully be experienced until that time comes.

Mr HUNT: The legislation is a bit young at the moment.

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Mr Sammon: That is right. The first payments are due by 10 May. If the units are not sold before that time, that is when the payments would start flowing to residents who have been out of their units for 18 months and have not had those units sold.

Mr HUNT: One of the purposes of bringing in legislation like this was the recognition of a smaller market for units such as these and the difficulties in selling them. It is almost creating an artificial buyer. Do you expect that to have an impact on the value of the unit?

Mr Sammon: I do not anticipate that there would be an impact on the value of the unit particularly because, as I mentioned, there is a process already established in the act that is used every day of the week in terms of identifying what the value should be. In particular, the resident and the operator get together and seek to agree on the value. If there is no agreement on the value, then the operator engages a valuer and that becomes the resale value of the unit. There is already a process in the act to do that. It is true that there might be disputes between operators and residents now and there might have been disputes along the same lines a couple of years ago about what that value ideally should be. There is already a process in the act to deal with the setting of that value and how that is to be resolved. That would be characterised as a retirement villages dispute if it was not able to be resolved.

Mr HUNT: What I am getting at is that it may even be advantageous to the operator in that a valuation may be given today and the operator is required to essentially purchase that unit back at that valuation. That operator would then later want to sell that unit but with the premise that legislation requires them to buy it back, which might increase the value, if you know what I mean. It may be that there is not a small market for this now. There is now a guaranteed market and that market force might drive up the price to the advantage of the operator.

Mr Sammon: Resident stakeholders, including the Association of Residents of Queensland Retirement Villages, have repeatedly raised with the department the importance of people having confidence in the retirement village regulatory system. People should feel confident that once they move into a retirement village they will be able to access their exit entitlement after a certain period of time. The department often gets correspondence from retirement village residents and their families indicating that they are unhappy about needing to wait for such a long period before their retirement village unit sells and that exit entitlement then flows back to the resident who has moved out and is trying to find some other form of accommodation using what would likely be their main piece of capital after they have retired.

Mr HUNT: Thanks for helping us to understand it better. I will change gear now to post-mortems. In relation to voluntary post-mortems, I am interested in how the current scheme works. There has obviously been a decline in voluntary post-mortems. We are not talking about mandatory ones where no cause of death certificate is issued. We are talking about when a doctor has issued a certificate of cause of death. Post that certificate being issued, who is usually looking to get consent for an autopsy? Is it the treating doctor or researchers? How does that operate in practice in terms of asking the next of kin or requests for that sort of thing?

Dr Bennett: This is not my area, so I will see if we have the detail on that. If there was not a compulsory post-mortem, that would normally be a discussion between the treating clinician and the family. It would be at either request—that would be my understanding—depending on the circumstances.

Mr HUNT: Obviously this has been brought to legislators and policymakers to overcome an issue. Somebody is obviously seeking to be able to do this. I am interested in whether it is treating doctors or researchers who are looking to delve into this field and who are after our help with legislative change for this—

CHAIR: Or family members.

Mr HUNT: Or family members.

Ms Law: We are talking here about consensual post-mortem examinations, and there is that restriction on them being in mortuaries. My understanding is that there has been a decline in the number of consents given for post-mortems. In some cases that is because of reluctance by the family to have a full post-mortem examination. This amendment allows for non-invasive post-mortems which we would hope would help encourage the rates of consensual post-mortems.

Mr HUNT: I understand that. I am interested in knowing who is seeking this. Is it the treating doctors, the researchers or both? Who has identified this as an issue for them?

Ms Law: Can we take that on notice and get back to you in terms of exactly who raised the issue?

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Mr HUNT: That is fine. I am trying to unpack what problem we are trying to solve here in terms of who needs this information.

Dr Bennett: My understanding is that, as you say, non-compulsory post-mortems would usually occur when there is uncertainty around the cause of death. It could be at the request of the family or the treating doctor. We will take that question on notice and get back to you. I suspect the answer is a mix of drivers around that with the intent to really make access to post-mortems more efficient for everybody.

CHAIR: In relation to those questions taken on notice, given that the closing date for submissions is not until 7 January 2019, we will advise you of the time the response is due by. We have a little bit of time up our sleeves.

Ms PEASE: I would like to go back to talk about the retirement villages. I actually worked on that committee. I was really impressed; you did a great piece of work, so thank you very much. I know it was a big undertaking and it has made a huge difference to a lot of people's lives. I used to work in advocacy for people who lived in manufactured homes and caravan parks, so I know that is important work that needed to be done. I have a small question with regard to the freehold owners. What happens if they pass away? Does that right pass on to the next of kin? Do they get access to that?

Mr Sammon: It does. Again, there are already processes in the legislation that deal with the passing on of retirement village residents. Essentially, the same process will apply when the person has passed on.

Ms PEASE: If they pass away when they are still living in the residence they have 18 months post their death to—

Mr Sammon: The only difference in that sense would be that the timing will not start until the operator receives the letters of administration of the probate—so the proof that the person who is going to be seeking to receive the payment is legally entitled to receive that. That is when the 18-month period will start. The operators are not required to start that time until they are shown the administration of probate.

Ms PEASE: Having said that, do the operators get access to that unit once the person has passed away, or do they still have to wait for probate to get access to it? It is the property of the beneficiaries of the will?

Mr Wall: I think we might check that answer if we can.

Mr Sammon: My colleague has just pointed out that the 18-month period does start, but there is no settlement required until the letters of administration of probate are provided. I apologise for that.

Ms PEASE: I am going to move away completely from that. I want to talk about the health risk and the notification of health risks arising from a pollution incidence. We experienced one at Brisbane Airport last year. Could you unpack that and give me some more information around what the new expectations are going be, particularly around the PFAS situation?

Dr Bennett: I can do that. In recent years, as you have indicated, there have been a number of pollution events in Queensland that have had the potential to cause a public health risk involving things like contamination of water supplies from PFAS, which is a chemical used in firefighting foams. Queensland Health thinks it is critical that Queenslanders are notified quickly where there is a potential risk to their health from a pollution event. The new power is necessary because the existing powers in the Public Health Act are focused on the event itself, such as requiring a remediation action to remove a public health risk, and the act does not empower Queensland Health to require a polluter to notify of public health risks.

Ms PEASE: What does that mean? The pollution episode does not have to be reported currently? They only have to report it if there is a resulting—what do you mean by what you just said?

Dr Bennett: When the government becomes aware of a pollution event, the current act, the Public Health Act, is really focused on requiring a response to that event. If there is a potential public health risk—

Ms PEASE: That is what they are going to do?

Dr Bennett: Exactly: remediating, cleaning it up.

Ms PEASE: They do not have to tell us when it happens; they just have to tell us how they are going to fix it?

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Dr Bennett: Yes. We require them to do that and get involved, whereas this new power is about the polluter notifying the public as well of the public health pollution event.

Ms PEASE: Notifying the public and the Queensland government?

Dr Bennett: Yes. The government will normally already be aware in that instance, but it places the onus of public notification on the polluter. The government will work with them to do that.

Ms PEASE: Is there a time frame as to when they have to do that notification?

Dr Bennett: Yes.

Ms Law: The chief executive will be able to set that time frame. The chief executive has the power to direct them about when the notice must be made by and what the notice must include. It ensures that the notice that is given to the public includes all of the information that the public needs to know about how to address the public health risks and a clear time frame to ensure that that notice is given in a timely manner.

Ms PEASE: Was there consultation around this particular aspect? Was it well received by the stakeholders?

Dr Bennett: There was wide consultation. I can get you a list of who was consulted shortly. It was by and large supported and endorsed by everyone. The LGAQ did have a view that this was already addressed in the Public Health Act. As I have said, the Public Health Act is really around remediation and response to the event rather than notification to the public.

The other request of local government was that the chief executive consult with local government. I think it was that they be required to consult with the local government before issuing the notice, which would involve a more extensive consultation process, and we feel that could delay the publication of a pollution notice at a time when there could be a significant risk to public health. For this reason, a requirement to consult has not been included. However, in the normal course of events, government would always consult with council on these matters.

Ms PEASE: To change the subject again completely, what happens now with regard to the dental area and the moving of radiation material?

Ms Law: They must apply to the department for a licence.

Ms PEASE: Each and every time?

Ms Law: For a use licence or a transport licence. In relation to the transport of substances into Queensland, I understand that is probably done on a case-by-case basis because those transport licences are not that common, whereas for a use licence, yes, a dentist who wants to use the intraoral equipment would need to have a use licence and apply to the department for that.

CHAIR: When I was the state MP for that electorate prior to the state redistribution I used to regularly attend northern beaches community consultation meetings. We had a number of complaints about the occurrence of ammonia smells. I was going to ask what you define as a pollution event. This came from the former Queensland Nickel refinery. A lot of residents were concerned about the very strong smell of ammonia, and there was some media around this. Do you think that constitutes a pollution event? The explanatory notes say that the chief executive requires 'a person responsible for causing a pollution event to publish a pollution notice' to warn people. I think that is effectively what needs to be done. Did you engage with industry? Whilst that particular refinery is shut—I know there are a couple of moving parts to this question—how did industry respond? I would imagine there is a maintenance issue when they clean stacks and things like that.

Dr Bennett: I might go to the first part of your question, which was defining a pollution event. The CE will have the responsibility to define a pollution event. Under the act it is defined as 'the release or dispersal of a pollutant or contaminant that may adversely affect public health'. As far as the practicalities of that, the details around the type of pollutant, how long that pollutant is likely to be dispersed, the known effects to health and how widespread it is all really point to its significance. The CE will make the decision in consultation with relevant department and industry groups. It is difficult to talk to each circumstance. It will be decided on a case-by-case basis. We expect only a few numbers every year of instances where it might be applicable.

Ms Law: In terms of consultation, we did consult with the Local Government Association of Queensland including the Queensland Water Directorate, SEQ and the public health units within hospital and health services.

CHAIR: It was just a matter of interest, because I remember that it was in the media in 2015-16 prior to its closure when residents were concerned about the very strong smell. I think industry has a responsibility to notify people if something is happening in that space.

PROOF

Dr Bennett: The other thing I would say is that, where other acts apply, they would need to be taken into consideration as well with respect to whether a notice is issued.

Mr McARDLE: I am going to leave the health issues aside until I hear submissions from the public, and then I will get you back at that point in time.

Mr Wall and Mr Sammon, in relation to the Retirement Villages Act I have a couple of questions. If I recall correctly, in the greens at page 11 it says that a scheme operator can make an application to QCAT to extend the time for purchase of the property. That is not contained in this bill. I suspect it is contained in the main act. Can an application be made more than once to QCAT? Is there a time limit? Must a purchase be completed by a certain calculated time event?

Mr Sammon: In response to the first question, we understand that an operator could make another application after making an application to QCAT for an extension of time. I am sorry, can you repeat the second part of your question?

Mr McARDLE: Is there a time by which a purchase must be completed, irrespective of how many times an application can be made, or can it be open-ended?

Mr Sammon: The bill does not prescribe that, I do not believe.

Mr McARDLE: There are circumstances where you may have four or five people selling out of the scheme which may all fall under the scheme operator having to buy that complex. It could well be that, though the intention is there, the outcome is the same, because you can get multiple applications to QCAT so the operator cannot afford to buy it. Is there an end scenario that we can look forward to, or really is it a matter of when the operator can afford it the purchase takes place?

Mr Sammon: That will be a matter, obviously, for QCAT to decide. The operator would argue the hardship impact—

Mr McARDLE: I accept that.

Mr Sammon:—and that would need to be balanced against the outcome not being unfair on the departed resident. The equation that the tribunal needs to balance is hardship against the outcome not being unfair on the departed resident. There would be a number of things that would need to be taken into account in that respect.

Mr McARDLE: One could envisage that an operator is, shall we say, cash poor and asset rich and therefore cannot really afford to buy one, two or three of these premises. That could go on for a long time, could it not?

Mr Sammon: I could not speculate about that possibility.

Mr McARDLE: In theory it could though, could it not?

Mr Sammon: In theory.

Mr McARDLE: How does the act and this bill deal with that issue?

Mr Sammon: It deals with it by giving the material that QCAT needs to consider in reaching that balanced outcome in terms of the hardship and the financial impacts on the operators against the outcome that would not be unfair on the departed resident. There might be a whole range of different factors that apply to that situation, both for the resident and for the operator. That is going to be a matter for the tribunal to determine on a case-by-case basis.

Mr McARDLE: How long do you think it would take for a matter to get through QCAT? Say we are 16 months down the track of the termination and then the operator says, 'No, I have to go to QCAT because I cannot afford to buy this.' How long would that take to get through QCAT, do you think?

Mr Sammon: I could not tell you what the length of the list is in terms of waiting to get on before QCAT; however, I am just recalling a provision in the legislation that seeks to deal with that in the sense that, in terms of the timing—sorry, I just lost my train of thought. I suppose the answer is that the legislation does not seek to prescribe an end date when QCAT needs to have a determination made in that respect, so the matters could go on. It would depend on when QCAT has availability.

The provision I was trying to remember was about the resident being able to bypass the mediation process before making an application to QCAT. If there is a dispute about the buyback situation, the retirement village dispute resolution process requires there be a mediation within the village between the village owner and the resident. If such a dispute involves these buyback provisions, that matter can be taken before QCAT without needing to go through those particular mediation processes, and that would facilitate the speeding up of the resolution of a complaint. I acknowledge that once it does get to QCAT then there is a time frame involved that is outside the control of this piece of legislation.

PROOF

Mr Wall: Obviously, the operator knows over a period of time its sales program and when people leave during that period, so they would probably have a good indication of what their sales are and how many people are leaving over a period of time between whether it is leased then, freehold or both. They would need to be working that through in a sales process.

Mr Sammon: During this process while the matter is before QCAT, for example, then the property will still be on the market and then when it sells the matter would be resolved by the fact of the sale.

Mr McARDLE: Once the operator incurs an obligation to buy the property, can the owner sell to a third party, bypassing the operator?

Mr Sammon: Yes.

Mr McARDLE: It can still sell in the open market?

Mr Sammon: Yes, that is described in the legislation as the private sale.

Mr McARDLE: Even if the operator has now a legal obligation under this bill to buy the property?

Mr Sammon: Yes. Just to clarify, not during the contracting process for the buyback.

Mr McARDLE: I am with you. A lot of these schemes have an arrangement whereby the operator is the agent for the sale of the complex, which has always caused problems in the past. Also there is a first option normally given to the scheme operator. I apologise that it is not in this bill, but does the act now deal with that? Is there a prohibition on an operator being by definition the agent/first option holder?

Mr Sammon: It does not deal with that specifically, but it does provide in 63F that there is no sales commission payable for a mandatory buyback.

Mr McARDLE: I was thinking wider than that.

Mr Sammon: The bill does not purport to deal with that.

Mr McARDLE: If I can take you to page 40 of the bill, subclauses (3) and (5) talk about the value and the purchase price. Subclause (3) talks about a valuation being obtained, and subclause (5) talks about unless they can agree, the purchase price of the freehold property et cetera must be the amount of the most recent agreed resale value of the freehold. I cannot quite gel those two together. How do they sit together?

Mr Sammon: I think that subclause (3) talks about the process if they have not agreed on a resale value, and it seeks to resolve that by saying that the operator must obtain a valuation of the freehold property from a valuer. Then subclause (5) seeks to—that is the recent agreed resale value as dictated by subclause (3).

Mr McARDLE: Are they different forms of agreement? Subclause (3) says that if the operator and a resident cannot agree then there must be a valuation obtained.

Mr Sammon: That is right—after a period of time.

Mr McARDLE: Subclause (5) says unless the operator and the resident agree, the purchase price must be the amount of the most recent agreed resale value. I cannot quite fit those together. I think they must refer to different things, but it is not clearly obvious to me on reading those two subsections. Is there a clarification that you can give me?

Mr Sammon: We might need to take that on notice.

Mr McARDLE: Sure. The last point I have relates to section 63E on the same page, 'reimbursement of scheme operator's legal costs'. It states that there should be some form of agreement to pay all or a part of the operator's costs involved. On my reading of subclause (3) it says that the valuation must be obtained by the scheme operator. Is that part of the legal costs referred to in section 63E, so that the operator must pay the valuation fee and cannot recover those moneys?

Mr Sammon: I would not believe they could under that section.

Mr McARDLE: This covers all types of dwellings under the act?

Mr Sammon: These amendments cover—

Mr McARDLE: My apologies. It highlights and corrects a perceived problem in the act as it currently stands.

Mr Sammon: That is right.

PROOF

Mr McARDLE: This would apply to a person who has the title of the house but only leasehold of the property as well?

Mr Sammon: No, it would be only freehold. They would have the title to the property and the land, as it were, under a freehold scheme.

Mr McARDLE: If this bill becomes part of the act, does the act then cover that scenario?

Mr Sammon: Yes, there is a new definition of freehold property that has been added by these amendments.

Mr Wall: But leasehold is part of the original?

Mr Sammon: That is right.

Mr McARDLE: Part of the original amendments back in November—

Mr Sammon: That is right.

Mr McARDLE:—cover the leasehold arrangements? That was where I wanted clarification.

Mr Wall: Where the words 'exit entitlement' were effective from, where this is really an agreed sale price.

Mr McARDLE: Freehold is quite distinct from exit entitlement. Thank you, Mr Chair. There is just one question on notice, if you could.

Mr O'ROURKE: Previously there were no protections or processes in place for owners of freehold title retirement villages, and I think so much work has happened in this space to try and unpick that. This is a step in the right direction.

Ms PEASE: I want to talk about the public health Notifiable Dust Lung Disease Register and how that has all come about. I understand that there was a great deal of work with the previous report that was tabled last year. Lung disease or dust lung disease events were not notifiable or not required to be notified; is that correct?

Dr Bennett: Not under the Public Health Act.

Ms PEASE: Were they required to be notified under any other act?

Dr Bennett: That is probably a little outside my scope.

Ms PEASE: That is okay.

Ms Law: Not that I am aware of.

Ms PEASE: This amendment came about because of that report, but since that time we have discovered that there have been other instances with manufactured benchtops. As a result, has that notification been adjusted to make sure that it is not just from coalmining but from all dust types?

Ms Law: Sorry, if I could just clarify my answer in terms of the notification, there is a scheme under the Coal Mining Safety and Health Act and Mining and Quarrying Safety and Health Act that requires a notification of certain coalmine dust lung diseases. That is an existing scheme. This will ensure that we have a register that captures all notifications of occupational dust lung diseases. It will pick up those existing notifications under the Coal Mining Safety and Health Act and ensure that Queensland Health has those and it will also ensure that doctors have to notify if they independently diagnose a case of dust lung disease.

Ms PEASE: It is just dust lung disease? We talked about PFAS and the side effects of that. Is that currently a notifiable public health issue?

Dr Bennett: Not under this legislation. This focuses on occupational inorganic dust lung disease.

Ms PEASE: Therefore, it is quite broad. That is quite effective, because it has just come to notice with regard to manufactured benchtops. No doubt there would be others.

Dr Bennett: Correct. There are a number—probably up to a dozen or half a dozen—different inorganic dusts that are known to cause occupational lung disease.

Ms PEASE: Have you seen a response by industry to better protect their workers immediately? This legislation has not come into play. Is the industry already responding to it?

Ms Law: The industry response to those types of illnesses would be handled by the Office of Industrial Relations. I personally do not have that information, I am afraid.

Ms PEASE: What do you imagine will happen once this legislation comes into place?

PROOF

Dr Bennett: Without being able to answer your specific questions about other actions—and I think a lot of those are probably tied up in other recommendations from the committee report—the intent of this legislation is to capture all of those notifications of inorganic dust lung disease with a certain amount of information. It is not really about individual cases but monitoring trends in disease and occupation and time and place. It will not be a public register. As I said, the purpose is to monitor and analyse the incidents. I think silicosis is a good example of that—looking at the number of notifications of silicosis and what occupations they are occurring in. There is a requirement for a report to be tabled annually by the minister.

Ms PEASE: Did you say it will not be a public register?

Dr Bennett: It is not a public register. It is not accessed by the public or employers. It is primarily for the purpose of government analysing and monitoring incidents and trends.

Ms PEASE: It is up to the medical practitioners to report to Queensland Health?

Dr Bennett: No, there are different avenues of reports. There are prescribed medical practitioners who are required to report. They are occupational environmental health practitioners or respiratory and sleep specialists. They are required to report either directly or, if they have a requirement to report to another body under different legislation, Queensland Health will access that information directly by the chief executive requesting that information from the chief executive of the relevant department. It will be a comprehensive catch-all either way to ensure that individual notifications are not missed. My understanding is that it was received very enthusiastically by the specialists in question. I think that is a good indication of compliance with reporting.

Ms PEASE: Thank you.

Mr BERKMAN: I forgot to ask a couple of basic questions about the amendments relating to medicinal cannabis. I understand that there is a huge variety of medicinal cannabis that serves different therapeutic purposes. At present, some are schedule 8 and some are schedule 4. There are no medicines left in schedule 9?

Dr Bennett: That is correct. Medicinal cannabis products have been rescheduled by the Therapeutic Goods Administration from schedule 9, which is where they were originally, to schedule 4 or schedule 8 depending on their composition of active product.

Mr BERKMAN: Does the simplification of the prescription process apply to all classes of medicinal cannabis?

Dr Bennett: Medicinal cannabis products will either be scheduled as schedule 4 or 8. That is my understanding. They will now be managed under the usual framework for managing schedule 4 and schedule 8 drugs—all drugs.

Mr BERKMAN: Is it correct that specialists are able to prescribe all of those schedule 4 and schedule 8 drugs without any additional single patient or prescriber class authorisation?

Dr Bennett: That is correct. That is in accordance with the current Queensland regulatory framework.

Mr BERKMAN: Thank you.

CHAIR: Are there any other supplementary questions from members?

Mr HUNT: I just want to go back to the retirement village legislation. I am trying to find the definition of 'valuer'. Where disputes are likely to occur is when the valuation is disputed. The valuer is to be engaged by the operator. I can imagine circumstances where the owner is not going to be happy with the valuer obtained by the operator with the suggestion that it might be one of his mates et cetera. Is there any recourse for the current owner to appeal that valuer's decision or is that just deemed to be the value at that point in time?

Mr Sammon: They could go to QCAT and take that as a retirement village dispute.

Mr HUNT: I am just trying to find the definition of 'valuer' and it has directed me to another part, so I do not have it.

Mr Sammon: Section 70A talks about a valuer's independence and says—

> In a valuation given under this division, a valuer must state any connection to, or agreement with, the scheme operator that may call into question the independence of the valuation.

That is in the current legislation.

Mr HUNT: Thanks.

PROOF

CHAIR: Thank you very much. We appreciate your time. Do you have some closing comments to make?

Dr Bennett: I was just going to ask if I could attempt to answer the question on notice—and, if not, we are happy to take it on notice—regarding post-mortem examinations. Whilst we do not have the specific information on the drivers and who is particularly driving it, as Ms Law said, it was noted that in the past 10 to 15 years there has been a significant decline in consensual post-mortems, which is largely attributed to changed community attitudes. I think from that you can probably infer that it is the treating clinicians who are driving it on the basis that there is a lot of information to be gained from post-mortems when there is uncertainty around cause of death, how effective treatments have been, whether it was an alternative cause of death—any number of questions that could be answered by a post-mortem.

It would seem that they are finding that there are barriers to post-mortems and primarily one of those barriers being the fact that, at the moment, there is a requirement to hold that in a mortuary and no real practical ability to use less invasive methods of obtaining information. I would infer that it is the practitioners and not research, per se, but really just for medical information. Any information gained for research must be done in a research approval framework regardless. The next of kin would have to consent for research, as they would have to consent separately for a post-mortem. I think we can infer that, if the family is asking for the post-mortem they do not see the current situation as a barrier, but it must be in this case. I would say that it is the treating clinicians driving it with a view to, I think, making a post-mortem more accessible for families to consent to, or more comfortable for families.

Mr HUNT: What is the situation at the moment? They cannot use radiology or scanning equipment on a deceased person?

Dr Bennett: I do not know for sure. I think the answer is that it is impractical. I expect that in some situations they probably try to get what equipment they can to the mortuary to be able to do that, but that it is largely impractical and may mean that that equipment is not where it needs to be all the time.

Mr HUNT: Certainly in my experience with policing, once you are able to do that very invasive examination, radiology et cetera would not necessarily take you any further. This is attempting to make these less invasive procedures available so that people will consent to it more readily.

Dr Bennett: I think that is correct. There may be one or two things like bone lesions that you do not readily see on invasive post-mortems that you might pick up on radiology.

Mr HUNT: Thank you. That satisfies my question. That is fine. They do not need to provide anything on notice.

CHAIR: I remind people that the closing date for submissions is Monday, 7 January 2019. I thank each and every one of you very much for participating today. It has been very informative as a starting point for the considerable amendments that are contained within this bill. We look forward to hearing from you again after the submissions have closed and we have any other questions. I know that there were some questions on taken on notice and we look forward to getting a response in due course. The secretariat will be in touch. Thank you very much. I now declare this public hearing closed.

The committee adjourned at 2.11 pm.

PROOF