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

Members present:

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

Staff present:

Mr R Hansen (Committee Secretary)
Ms A Beem (Assistant Committee Secretary)

PUBLIC HEARING—INQUIRY INTO THE QUEENSLAND GOVERNMENT'S RESPONSE TO COVID-19

TRANSCRIPT OF PROCEEDINGS

WEDNESDAY, 19 AUGUST 2020

Brisbane

MONDAY, 19 AUGUST 2020

The committee met at 9.02 am.

CHAIR: I now declare this public hearing 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. Today's proceedings are being conducted using videoconference and I would ask you to please bear with us if we encounter any technical difficulties. I am Aaron Harper, the chair of the committee and member for Thuringowa. Members of the committee joining us today via videoconference are Mark McArdle, the member for Caloundra and deputy chair, and Marty Hunt, the member for Nicklin. Here in the room we have: Joan Pease, the member for Lytton; Barry O'Rourke, the member for Rockhampton; and Michael Berkman, the member for Maiwar, who will be joining us soon.

The purpose of today's hearing is to assist the committee with its inquiry into the Queensland government's health response to COVID-19. This hearing is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. Hansard is recording the proceedings. You will be provided with a copy of the transcript. This hearing is being broadcast live on the parliament's website.

FLYNN, Mr James, State Manager (Queensland), Royal Australian College of General Practitioners (via videoconference)

WELLARD, Ms Jess, Executive Director, Assessment and Resolution, Office of the Health Ombudsman (via videoconference)

WILLETT, Dr Bruce, Chair (Queensland), Royal Australian College of General Practitioners (via videoconference)

CHAIR: Dr Willett, would you like to make a brief opening statement before we proceed to questions?

Dr Willett: Yes, I would love to. First of all, thanks very much for the opportunity to be here today. I would also like to acknowledge the traditional owners of the land on which we are all meeting, the Turrbal people, and pay my respects to their elders, past, present and emerging. The Queensland RACGP represents over 7,900 general practitioners and GP trainees who conduct over 25 million general practice consultations in Queensland every year. Additionally, our general practices provide employment to an estimated 24,000 practice nurses, receptionists and allied health professionals. On behalf of the RACGP members and those working in our practices, I would like to thank the Queensland government for their amazing response to the challenge that the COVID-19 pandemic has presented. It has been a truly awesome effort. As frontline healthcare workers, GPs are enormously proud to work collaboratively with the Queensland government and the public health units to keep our communities safe. The current pandemic has highlighted the essential role that GPs and their teams play in responding to community emergencies.

One of the challenges faced by general practices early in the pandemic was that we received discordant advice from state and Commonwealth authorities. This caused anxiety and confusion. While this was resolved relatively quickly under the circumstances, it was quite difficult for GPs and our patients alike for some period. The RACGP believes that the lessons learned here can be applied to facilitate a more comprehensive and cohesive response in the future, especially in the planning and initial phases of disaster and pandemic.

The RACGP Queensland proudly notes that Queensland was one of the best performing states in terms of rolling out the National Influenza Immunisation program. Nevertheless, the COVID pandemic underlined and exaggerated some of the underlying problems with the program and we look forward to these issues being addressed in future vaccination rollouts. Influenza vaccination availability for general practices lagged significantly behind the timing of the health promotions regarding these vaccines. This resulted in some vulnerable patients becoming frightened about the availability and the timeliness of the influenza vaccines and seeking less effective vaccinations in

retail settings incurring unnecessary costs. Additionally, the majority of these vaccinations were not recorded in the Australian Immunisation Register and this caused issues for GPs following up on these vaccinations for patients.

The RACGP would also like to celebrate and draw your attention to the excellent work of Queensland GPs in keeping our communities safe during the COVID pandemic. GPs have worked tirelessly in their communities, having to rapidly pivot to telehealth consultations and overcoming technical and system challenges in the process. In just a few weeks general practices had also implemented significant changes in the way they work. They had developed creative new ways of working in order to continue to deliver safe and essential care to their patients and their communities. Examples include GPs setting up outdoor clinics to deliver influenza vaccinations and the establishment of respiratory clinics right across the state. An RACGP member survey showed that 97 per cent of general practices remained open during this time. GPs provide approximately 60 per cent of all COVID testing in Queensland and form a crucial part of the state's pandemic response. In addition, GPs have been able to provide the necessary follow-up and ongoing care and counselling to patients who have attended fever clinics. Unfortunately, GPs do not currently receive the COVID test results from fever clinics. The RACGP recommends that the patient's usual GP receive a copy of the COVID results because they are essentially coming back to see us for follow-up of those tests and it is particularly relevant in negative tests where they require a diagnosis.

During COVID-19 hospital outpatient services were put on hold for category 2 and 3 patients, with a great deal of variance of approach across the various HHS settings. General practice continued to care for these patients over this period and we believe we can build on this experience. General practice has proven to be the most cost-effective part of our healthcare system. There are currently unique opportunities for greater collaboration between hospital services and general practice based care in our community. This could reduce costs, drive efficiency and treat patients closer to home, which generally suits most patients. Future directions might include GP-led hospital in the home, GP-led hospital in the nursing home, GP-led mental health services in the community and shared antenatal care arrangements.

Finally, once again I would like to really thank the Queensland government, in particular Dr Young and her team, for their continued efforts during the pandemic. We look forward to working more closely with the Queensland government to effectively serve the healthcare needs of all Queenslanders in future. Thank you.

CHAIR: Thank you very much. Ms Wellard from the Office of the Health Ombudsman, would you like to make any comment before we go to questions?

Ms Wellard: Thank you and good morning. Thank you for the invitation to attend today's public hearing. I have been asked to pass on Andrew Brown's apologies for being unable to attend today. Before I go further, I want to also acknowledge the scale of the public health response in Queensland thus far and the substantial amount of work that has been undertaken by health practitioners, hospital and health services and public health officials in responding to this unprecedented event. As expected, given the OHO's role and functions, a notable proportion of the complaints and inquiries to the OHO between March and June this year related to the COVID-19 pandemic—approximately one-eighth of contacts received. Overall the volume of complaints and inquiries about all matters was lower than normal levels during April and May by about 25 per cent. This we attributed partly to the reduction in the number of health services being delivered during the initial stages of the pandemic. Since June complaint numbers have returned to at least pre pandemic levels.

The OHO has been responsive to risks arising to the public from the pandemic by identifying and referring matters that raise public health risks and by providing information to people who contacted the OHO. However, the OHO has tempered its approach to this extraordinary situation by adopting a deliberate and cautious manner, being careful not to divert critical frontline health resources in order to respond to non-urgent complaints. Some less urgent matters were temporarily placed on hold as the pandemic response unfolded. As outlined in Mr Brown's letter to the committee, the OHO received complaints covering a wide range of issues. I also want to note that it is not surprising that complaints were received that related to health services delivered during the pandemic. Given the impact that COVID-19 has had on the health sector in Queensland, it would have been more surprising not to have received complaints about health services that were impacted or were perceived to have been impacted by COVID-19.

Further, as the committee would be aware, receipt of complaints is not evidence that criticism of a specific health practitioner or health service facility is warranted. I can certainly make an observation that some complaints appeared on their face to be the result of misunderstandings of COVID-19 or the relevant public health directives and other complaints may well have been borne

out of anxiety about the pandemic situation. Around 30 per cent of complaints resulted in no further action being taken. I can advise the committee that to date no COVID-19 related complaints have progressed to investigation or formal findings by the OHO. Around 60 practitioner complaints were referred to AHPRA and almost 30 complaints referred to other entities. Using the new section 35A, which enables the OHO to provide early advice and assistance to a complainant in situations where it is reasonable for the complainant to first raise the issue with the health service provider, approximately 20 per cent of complaints received that related to COVID-19 were redirected to the health service provider in the first instance. However, the OHO considers that some of the themes arising from this complaint information may still be useful for planning in future pandemic responses which prompted the submission to this inquiry. The complaints data provides useful information about how health service consumers experienced the pandemic and what challenges they found. Thank you for the opportunity to appear before you today and I look forward to answering any questions the committee may have.

CHAIR: Thank you, Ms Wellard, and thank you for the work the OHO continues to do. Can I also thank the RACGP and the broad network of GPs that we have out there seeing people throughout COVID. We only have to go back a number of months to see the challenges—I am just noting both of the submissions—of getting people to see their GPs when there was a fair bit of anxiety in the community. Queensland is in an enviable position. I think we can acknowledge the work of Dr Young for the position we find ourselves in compared to other states.

I point to last note, No. 7, in the OHO's letter. I think the RACGP might have a comment on it as well. I cannot quite find the submission that talks to the issue of funding for telehealth running out in September. I note the OHO had some issues around billing and telehealth consultations. Can anyone confirm or make comment that that might be the case, that indeed funding for telehealth might be running out or ceasing in September, and what impacts that might have from a GP point of view?

Dr Willett: Officially, the telehealth funding runs out at the end of September. The RACGP is talking with the government and working hard to get an extension of that. We are cautiously optimistic that some form of telehealth will continue after September. I think it would be very difficult to wind it up completely under the current circumstances. We all know that this is not over yet. If you ask my opinion, I suspect there may be some changes at the end of September, but I would be cautiously optimistic that it will continue even though there is no announcement yet.

CHAIR: Ms Wellard, did you have any points to make on that?

Ms Wellard: I would not want to comment on the availability of the telehealth service or the funding of it. Having queried the complaints and inquiries raised in the COVID-19 context and noting that there may well be complaints and inquiries that do not relate to COVID-19 but still relate to telehealth more generally, a lot of the concerns raised appeared to be along the lines of differing expectations between perhaps the consumers and practitioners around when telehealth might be appropriate or might be offered and whether that was preferred, and also questions and concerns around billing and cancellation costs. As the delivery of health services via telehealth is still an emerging area of health care in Queensland, I really cannot offer any further insights on the issue, other than perhaps to comment that some of the complaints may relate to teething issues and may iron out over time and I guess we will see if that happens.

CHAIR: Dr Willett, I note at 3.2 of your submission, you talk around PPE. I want to go to that point. It states that there seems to be some—

> … logistical challenges faced in ensuring PPE was made available where it was needed most appeared to overwhelm some PHNs.

That is quoting your submission. I wanted to address that with you because your recommendation goes on to talk about, 'The Queensland Government should urgently address the supply shortages of PPE.' I note that the Premier was at a massive warehouse just yesterday or the day before with significant stock being shown there. Can I ask, Dr Willett, who is responsible for supplying GPs and the GP network with PPE?

Dr Willett: That is the question and the frustration that GPs have found themselves in. This is the classic problem of our Federation model and the split of health between state and federal jurisdictions. We have taken the majority of our lead in general practice in Queensland from Queensland Health and the Public Health Unit's directions because they have the most immediate bearing on the way we operate. The federal government has been tasked with supplying PPE through the PHNs, but that was just simply not available. There are certainly areas in rural Queensland where this has been the main problem and where GPs do need to do the COVID testing themselves because there is no other source available and they were struggling to get PPE and it was the cause of a great deal of anxiety. I think if we find ourselves in a Victorian type situation that may be a problem again.

Mr Flynn: Adding to Bruce's comments, under a normal operating process, GPs as private practitioners source their PPE from private suppliers, not from the national or state stockpile. One of the very early issues that a large number of GPs, not just those in Queensland but across the country, encountered because the vast majority of that PPE comes in from overseas suppliers, was that GPs could not access the PPE supplies from their normal suppliers. Even when they were able to access it, a large number reported to us that their supplies were intercepted mid-shipment for the national and state government stockpiles which further created those challenges and frustrations that we mentioned in our submission. That compounded that part of the problem.

CHAIR: Thank you, Mr Flynn. It would be my observation that you perhaps include in that recommendation that the Australian federal government strengthens the primary healthcare network. They are responsible for the supply. Yes, I take on board Dr Willett's comments around the relationship with Queensland Health, and I am sure there can be some secondary backup, but we cannot have GPs in the position where they are having to go out and buy their own. I do think that the PHNs need to be somehow fundamentally strengthened so they can logistically supply in times of great need, such as COVID-19. I open up to questions from the committee.

Ms PEASE: I would also like to acknowledge the great work of the GPs out in the community and acknowledge how hard they have worked. I have spoken to many of them during and since the pandemic. One of the things I would just like some clarity on, Dr Willett, was that you mentioned GPs are responsible for undertaking 60 per cent of the testing for COVID. Just for clarity sake, is that a referral to a private provider, like a Sullivan Nicolaides or whomever, to do the testing; is that correct?

Dr Willett: Yes, that is correct.

Ms PEASE: Then you have said that they do not receive the advice of the tests.

Dr Willett: There are two aspects. They will automatically get those results back and generally very quickly from the private providers. The issue is with patients who attend state government funded fever clinics associated generally with hospitals. Those results are not forwarded onto the GPs. The problem is that the patients are then told that they do not have COVID; they are not told what they do have. Naturally, a fair proportion of those patients will then seek advice from their GP to get a diagnosis and a management plan because that is not provided in a fever clinic. It is obviously very helpful—

Ms PEASE: What I am trying to understand is that that comment about not receiving the advice is because people are presenting at fever clinics independently of going to their GPs?

Dr Willett: Correct. There are two ways to get a test. There is either—

Ms PEASE: Yes, I understand that. I was trying to get some clarity around that. The people who are presenting to the fever clinics or the public health centres to get their test, are doing that independently rather than going through their GP?

Dr Willett: Correct.

Mr HUNT: I had similar questions to the member for Lytton. Also on your comments, Dr Willett, around the availability of the flu vaccine and people seeking out less effective or something—I forget the term you use, but some sort of retail vaccine. What are you talking about there?

Dr Willett: There was an announcement that people should go and get their flu vaccine early during the pandemic. The Commonwealth funded flu vaccinations were not available at that stage, so a lot of patients became very anxious. There was aggressive advertising from some pharmacies to go and get the flu vaccine at the pharmacies. The issue there was that for elderly and immunocompromised patients, the private vaccines are a lower dose vaccination so effectively these patients are receiving a less effective vaccine ahead of getting the correct vaccine and, additionally, they had to pay for that. The other issue is that there is a high proportion of those vaccines that are not recorded against the national immunisation register; possibly less than half of those are recorded. That is according to the National Centre for Immunisation Research and Surveillance report in May.

Mr HUNT: Are you saying that if you go to the pharmacy for a vaccine, it is a lower dose or a less effective vaccine?

Dr Willett: Yes, the ones provided by the pharmacies are a lower dose than recommended for over-65 and immunocompromised patients. It is a different vaccine. It is still a flu vaccine and, quite frankly, it is better than not being vaccinated at all, absolutely. Anything that improves vaccination is good. It was just an issue that patients were getting a vaccination that was not the most appropriate for them even though it is still much better than nothing.

Mr McARDLE: Dr Willett, in your submission, you refer to the Australian Health Protection Principal Committee, which is a body made up of all Australian state and territory chief health officers. First of all, do you know when that body first met?

Dr Willett: No, I do not. It was quite early. When it did meet, it made a big difference. It was one of the things that really meant that things started to coordinate and we got a more consistent level of advice.

Mr McARDLE: Are you aware of the recommendations that it made that were then picked up by the federal, state and territory jurisdictions?

Dr Willett: Not all of them, no.

Mr McARDLE: Are they recorded somewhere that we could go to, do you know, and on their website?

Dr Willett: No, I am not aware.

Mr Flynn: We could have a look for you, but I imagine Dr Young's office, sitting on that committee, would have access to the recommendations from that committee.

Mr McARDLE: If she does not have them, would you undertake to look for them?

Mr Flynn: Absolutely, yes.

Mr McARDLE: One of the issues for the committee is to look at what has to be put in place to control the spread of any infection—pandemic et cetera. PPE would have been top of the list, or very close to it, because it is that contact with people where we need to put a barricade up to stop infection from occurring. We know that PPE can be sourced from state, federal and, Dr Willett, you said, private bodies as well. By the time COVID-19 or coronavirus hit Australia, China had been swept and China was buying up large quantities of PPE. It would have been important at that point in time for that body to put in place a regime to establish, one, how PPE would be acquired and, two, how PPE would then be distributed to GPs, Queensland Health and other state and territory bodies. Would that be correct?

Dr Willett: That is correct. To be clear, general practice buys all of its PPE from private sources. The issue was that we could not; it was not available.

Mr McARDLE: That is exactly right because it had been consumed by overseas jurisdictions buying up before we were hit.

Dr Willett: Absolutely.

Mr McARDLE: Therefore we were faced with a situation where Queensland Health was saying their stockpile related only to Queensland Health facilities, based upon your submission at page 5, and the PHNs were in a similar position themselves.

Dr Willett: Correct.

Mr McARDLE: It appears, at least in the early stages, the PPE was left in abeyance, or at least there was no deferral to a plan; the GPs had to come to their own solution to access PPE, would that be right?

Dr Willett: That is absolutely accurate. It meant GPs, myself included, going to Bunnings and buying masks and face shields and trying to adapt hardware equipment to provide a level of protection for people working in our practices.

Mr McARDLE: I understand from your submission that Queensland Health said, 'No, it is only for QH facilities'?

Dr Willett: Yes.

Mr McARDLE: The PHNs could not assist either?

Dr Willett: They had very limited stocks, so they just were not available.

Mr McARDLE: Would that explain why the Queensland government went to facilitating organisations that did not normally develop sanitisers and masks to incentivise them to do so?

Dr Willett: Yes, and that was an excellent response.

Mr McARDLE: I want to talk about telehealth. I have a recollection that there was some pushback in relation to how effective telehealth was in certain circumstances. It needed to be refined to move forward in the COVID-19 pandemic. Can you comment on that?

Dr Willett: Absolutely. As has been stated earlier, there are issues where it is appropriate and where it is not appropriate. What is clear is that not all medical practice can be conducted by telehealth. The figure I would give is about 30 per cent of general practice is appropriate for telehealth. You do have to examine patients at times. There is still some difficulty about managing that expectation about when it is appropriate to do things by telehealth and when it is not.

Mr McARDLE: I want to conclude by congratulating GPs right across the state, and across the nation in fact, for the great work that they did. It needs to be remembered that they have employees who are also liable to become infected. The care you gave to them and to the community is exceptional. Well done.

CHAIR: I certainly echo those sentiments. I thank Dr Bruce Willett and Mr James Flynn from RACGP and Ms Jess Wellard from the Office of the Health Ombudsman for your time this morning.

BLACK, Ms Jennifer, Chief Executive Officer, Queensland Alliance for Mental Health (via videoconference)

EMMERSON, Professor Brett, Chair, Queensland Branch, Royal Australian and New Zealand College of Psychiatrists (via teleconference)

GOMEZ, Ms Lourdes, Senior Adviser, Policy and Sector Development, Queensland Alliance for Mental Health (via videoconference)

RHODES, Ms Amelia, Policy Manager (Branches), Royal Australian and New Zealand College of Psychiatrists (via videoconference)

CHAIR: I welcome representatives from the Queensland Alliance for Mental Health and the Royal Australian and New Zealand College of Psychiatrists. While we wait for Professor Emmerson, we might start with the Queensland Alliance for Mental Health. I invite you to make an opening statement, Ms Black?

Ms Black: The Queensland Alliance for Mental Health is the peak body for the community mental health organisations in Queensland. That is generally the not-for-profit organisations that support people with serious mental illness on the whole. Most of their work is community based. The feedback that we give is based on feedback from our members who were delivering services during the height of the COVID-19 pandemic in Queensland.

I would make a couple of broad comments. The first is about communication with the department. There were regular meetings from the community funding branch which were extremely helpful because the information was changing on a daily basis and we were trying to interpret what that meant for the community mental health sector. Whilst they did not know all the answers, they were there trying to hear our issues and trying to come back the next day with answers, so that was useful.

For our sector, there was a lack of clarity about whether they were essential services—which we finally did get. For very small organisations that were really struggling to work out whether they should still be providing services—and the bulk of their services were face to face—it was quite anxiety provoking for quite a long time and it probably left them with a lot of queries unanswered.

There was a big problem in our sector with access to PPE. Whilst we were informed that it was not necessary for home visiting, I think it was complicated by the different views in the media and different reports around the world about whether masks and PPE should be used in public spaces and those sorts of things. Probably what it did was lead to anxiety from both consumers and staff about whether they should have access to PPE. It just was not available to the community mental health sector. It was being prioritised for GPs—which I totally understand. What it probably led to in our sector was real anxiety in the workforce and high absence rates of staff who were delivering direct services.

If we do see a second wave in Queensland, that will need to be addressed. I suspect that people will be demanding PPE given that we now see in Victoria that it is mandatory. There is every bit of PPE on the market that you can buy but not necessarily all of it is the right grade, so great communication and education for our sector would be important, I think.

The community mental health sector struggles with keeping a qualified workforce at the best of times, particularly in regional and remote locations. We saw high absence rates of staff. I think that was fuelled by the anxiety of COVID-19 and the lack of PPE and the need to protect their own families. There were conversations between HHSs and the community sector about them needing to do more work in the community to support people. That required a surge workforce that was not necessarily there. That would need some consideration in terms of any second wave that we have.

A lot of our organisations are very small organisations and they were very concerned about the OH&S implications if their staff got sick and what that would mean for them as small organisations. They were being told by Safe Work that, yes, they would be responsible if someone got sick but they did not have access to PPE. The level of anxiety was quite high in relation to that, as you can understand.

The final comment I would make is around telehealth and going remotely, which a lot of our services did. What they were finding was that a lot of their clients did not necessarily have access to technology, so that was not a solution for all and particularly for multicultural organisations. Most of

them just remained face to face through the height of it because they did not have access to interpreting services or language services and were not funded to provide those. They are my general comments.

CHAIR: Thank you very much, Ms Black. We are waiting for Professor Emmerson to join us, so I might put a quick question to you before we go to other speakers. Who would normally supply PPE to mental health workers?

Ms Black: In the community sector, generally we would not need PPE. I think that was one of the issues. Within the media it was being hyped up a bit with regard to should you wear a mask or should you not wear a mask. The government advice was that you did not need a mask if you were home visiting. If you social distanced or did your home visits on the porch, you would not need a mask unless someone was deemed to be positive, but that did not deal with the anxiety of both the consumers and the staff. My point is that, if we go into a second wave, because in Victoria masks are mandatory now for the general population, I think that will add to the issue. Our sector would need training in the use of PPE.

CHAIR: You talked about direct messaging available on multiple platforms. In your submission you talk around the Victorian government releasing information via text message and email to holders of a Victorian driver's licence and those registered for public transport. Can you unpack that a little bit more in terms of what messaging we might get out there during a pandemic and how that has assisted?

Ms Black: I think the issue was that things were changing daily: 'Today we are introducing X, Y and Z.' I think because it was changing so rapidly it was difficult to keep up and translate how that worked for the community mental health sector. Whilst there might have been messages on TV, social media et cetera, we noted that in some of the other states they did a bulk text to people and that sort of thing to say what the updated information was. We thought that might be useful, particularly when things are changing so rapidly.

CHAIR: I apologise, Ms Rhodes, for putting you on hold. We would normally get both organisations to make an opening statement before we move to questions. Given that we are waiting for Professor Emmerson, do you want to make an opening statement now before we move to questions? Ms Rhodes, can you hear us?

Ms Rhodes: I could not hear you, but now I can. I understand your committee secretary is manually adding Professor Emmerson into the call. There seems to be some issue. I am not quite sure what is going on. He should be with us momentarily.

CHAIR: We are having technical issues with zoom, but this happens. We should all be pretty good at using these platforms now. Professor Emmerson, thanks for joining us today.

Prof. Emmerson: I am having technology problems.

CHAIR: That is okay. We can hear you okay on audio.

Mr McARDLE: Sorry, I cannot hear the professor. He is very soft.

CHAIR: We will move the microphone. Professor Emmerson, did you want to make an opening statement?

Prof. Emmerson: My understanding is that you are seeking the college's opinion on the government's response to the COVID crisis. Is that correct?

CHAIR: That is correct.

Prof. Emmerson: As a college, there are probably four areas that we would like to comment on. The first area is the work of the Chief Health Officer. The college has been contacted and has had a number of meetings with the Chief Health Officer and Queensland Health. I think they have done an excellent job in keeping the sector advised and working with the sector. We give Jeannette Young's area a big tick. As I say, I think they have done good consultation.

In terms of the government's actions in the area of dealing with the mental health of people in the quarantine hotels, particularly the response to what they have done in the homeless sector, they have taken a lot of people who would be either sleeping rough or ad-libbing it in places like Pindari and the other three homeless centres and they have taken over student accommodation at Atira. I think they have 300 people there. That has proved to be highly successful, getting homeless people into individual accommodation with their own bathrooms where they cannot spread the virus. As I say, if they were on the streets, they would have a very high chance of cross-infecting. Again, we give a pretty good tick from the college of psychiatrists in terms of how the government has responded to that.

There is probably a need for the college to highlight that there is a lot of distress in the community. I think we are starting to see probably a rise in suicides. Certainly, the mental health services are seeing increased requests for assessment and support from sectors of the community that we would not traditionally see. I am the executive director of Metro North mental health and we cover the mental health services for the north of Brisbane. Our links with the PHN everywhere are much busier than we were previously. There will be probably two or three years of increased work needed. If Queensland is to recover, we will need to probably see additional resources into the area of community mental health. We have just seen with Victoria the Commonwealth announce $32 million for 15 new centres for Melbourne. I think Queensland needs to look seriously at doing something similar. The only minor whinge we as a college might have is that early in the crisis there were shortages of PPE, but that seems to have been corrected now. As I say, hopefully we will never have to use them, but I think stocks are now adequate.

CHAIR: Thank you very much, Professor Emmerson. Do you have any concerns about telehealth funding ceasing in September? In its submission, Asthma Australia made the comment about how important it is for people to have access to services. I see Ms Rhodes is nodding her head.

Prof. Emmerson: I can make a couple of comments. One is that the access to telehealth should continue. I would offer some caution. What we have noticed here, particularly in Metro North, is that for some groups telehealth and being able to get a mental health consultation quickly has been very advantageous, but for certain groups it has not worked. In the last month, we have seen a major increase in people with eating disorders presenting to mental health services. Over the two or three months of the lockdown when people were operating via telehealth, nobody noticed that a number of people with eating disorders had lost 12 kilograms over that time. It has not served the eating disorder population well.

The other group that have been particularly impacted, but probably do not know how to use technology, is the older age group. Certainly at Royal Brisbane we have seen a doubling in the number of people admitted. Normally we would have 10 beds out of our 75 occupied by people over the age of 65. Currently, we have over 20. As I say, telehealth is a great option to have and one that I have certainly used for my clozapine clinics on a Tuesday afternoon; however, as I say, for eating disorders and the elderly it has not worked. Equally, I think telehealth is a great option but I still do not think it gets around the need for face-to-face and one-to-one interactions in psychiatry, because our therapy works very much around that one-to-one relationship.

CHAIR: Thank you, Professor Emmerson. Did the alliance have any comments?

Ms Black: No. I agree with Professor Emmerson. I think that is right. It needs to be one option but some people will not respond to that option. The whole basis of working with people with mental health issues is developing relationships, which is probably harder to do, and an observation of how they are managing at home as well. I would agree.

CHAIR: Thank you. I will open to questions.

Mr BERKMAN: Professor Emmerson, you referred in your opening statement to the changes at the Atira building and the movement of some fairly high-need supported accommodation into student accommodation. That is in my electorate. It has certainly not been without its impacts on the local community, but I am interested in the successes that you have referred to. Can you speak further to what kinds of positive outcomes you are aware of that the residents at Atira have experienced?

Prof. Emmerson: The major one is it gets them off the street. The possibility of them mixing with a potentially infected person has been greatly reduced. The quality of their existence and everyone having their own studio accommodation is positive. From a service point of view, I oversee the metropolitan homeless team or the HHOT team here. Being able to go into the one facility, find all your patients, have interview rooms available with security should something go wrong, and then also have access to all the PPE if you need it has made service provision from a service provider point of view much easier. The other thing about having a number of these people at the one site is that sometimes as a population you cannot find the particular people you need to when you need to see them. For example, if their antipsychotic injection is due every two weeks, finding the homeless person on the day it is due is sometimes two or three hours work. If they all are at Atira, it makes finding them and providing the treatment much easier. The benefit for the consumer is the fact that they are actually getting their treatment on time, which makes a big difference.

Mr BERKMAN: I do not know if the Alliance for Mental Health has had anything to do with the work going on in that space and had any comment?

Ms Black: We just lost connection, so I am not sure what the question was.

Mr BERKMAN: That is okay.

Mr O'ROURKE: Professor Emmerson, we were just talking about the homelessness issues and having people in supported accommodation. Of the number of people who are homeless, what percentage have mental health issues?

Prof. Emmerson: It depends which surveys you look at, but anywhere between 30 and 50 per cent. Again, it depends on your definition of 'mental illness'. If you include all the drug and alcohol issues, if you talk about people with personality disorders and that sort of thing, probably 30 to 50 per cent would be a conservative estimate. The other thing to say is that areas closer to large metropolitan centres like Melbourne, Sydney and Brisbane tend to attract people with schizophrenia much more than other areas. Depending on what city you are in, the closer you are in, the more likely you are to see people with severe mental illness.

Mr O'ROURKE: With that supported accommodation having a lot of people with high-support needs, given the nature of homelessness, has that impacted on other residents? Is it sort of feeding off one another and making it even more difficult to manage?

Prof. Emmerson: Not that I am aware of. I have not seen or heard of cases of that.

Mr HUNT: Professor Emmerson, you mentioned briefly in your opening remarks rises in suicide. Is that anecdotal or is someone keeping a track of that? Are you watching the trends in that area or is there any comment you can make specifically in relation to that?

Prof. Emmerson: Certainly our impression in Metro North is that suicides are up. About two weeks ago I was at a professional function with Professor David Crompton, the Director of the Australian Institute of Suicide Research and Prevention at Griffith University, and his assessment is that the suicide rate is up by about five per cent so far. That is their assessment. There is a government target to try and halve the suicide rate by 2025, I think. I am not sure that we will see that with this COVID epidemic and then the economic impact that this will have on so many people.

Mr McARDLE: Ms Black, thank you for your submission and your opening statement. You referred to PPE and the fact that there was confusion in the mind of the public, 'Do I wear a mask, do I not wear a mask—

Prof. Emmerson: Sorry, I am having difficulty hearing that clearly. It was very unclear, sorry. Could you try that again, please?

Mr McARDLE: Certainly. It is actually to Ms Black. The question revolved around Ms Black's statement that one of the issues the community sector had was access to PPE for their employees. Ms Black said that because PPE messaging was not clear in the minds of the people who worked in the sector and that whether wearing a mask was good or indifferent raised anxiety in those who work in the sector. Traditionally, what age group are the workers in the community sector under the Young Mental Health Alliance?

Ms Black: The sector has staff from all age groups. Possibly, some of it is an ageing workforce. They would have people from all age groups.

Mr McARDLE: It appears from what we hear that as you age in this environment your anxiety level tends to increase. The messaging has been that if you are over a certain age you are at a greater risk of an outcome from COVID-19 that could be a lot worse than for a younger person. I am just trying to correlate the mask issue to that age group, or are you saying right throughout the sector it did not matter what age group it was as the anxiety was there?

Ms Black: I do not know that we know where it was coming from. It was just reported from our members that, even when they went to visit some consumers, they would not be allowed in the door or to visit because of the public anxiety about people coming in to do a home visit without a mask. A lot of workers have elderly parents. It was not just necessarily themselves that they were thinking about; they were thinking of their families as well, which raised the level of anxiety.

Ms Gomez: I would also add that with the diverse communication globally, having such restrictions (portion of audio missing) effectively stage 4—there was a lot of concern and confusion about what was Australia's response, what is Queensland's response. Very early on, I suppose there was that confusion (inaudible).

Mr McARDLE: Professor Emmerson, the answers given by the Mental Health Alliance then raise the question to you. As you mentioned, we have a lot of older people in nursing homes who I think may have been the most impacted, or at least one of the most impacted groups, because the homes are shut down, opened up, shut down and then opened up. I am not arguing the point of why they are shut down; I am making the comment that they are shut down. We also have people in the community who have businesses and are losing custom at times and then open back up. How broad is this anxiety extending across the populous? Every time we close the borders with New South Wales

or Victoria, there is an underlying message that people pick up and they become anxious. How wide do you think this impact is on the mental health of Queenslanders? More importantly, you mentioned two to three years of increased work and additional resources are required. Can you define that for me in some manner?

CHAIR: Deputy Chair, I do not know whether Professor Emmerson heard that.

Prof. Emmerson: Can someone just summarise that for me? Whoever just spoke then is very clear, but the previous speaker I could not really hear.

CHAIR: That was the deputy chair.

Mr McARDLE: Could I suggest that we write to Professor Emmerson with that question and he can then respond.

Prof. Emmerson: I am happy to answer it, but what is the question?

CHAIR: Sorry, Professor Emmerson, the deputy chair was asking about border closures and the impacts of—it sounded like anxiety to consumers or businesspeople. Would that be correct, Deputy Chair?

Mr McARDLE: No, there were several components.

CHAIR: If you put it in writing we will take it on notice.

Mr McARDLE: Thank you.

Prof. Emmerson: One thing I can say is that there is heightened anxiety throughout the community as soon as there is uncertainty. There are a very large number of people who are facing uncertainty about accommodation, whether they have a job, social security, JobKeeper changes are coming up, and there is a great unknown. People respond to that in a normal way, which is to get anxious. Unfortunately, there has certainly been an increased use of alcohol. With the stimulus packages that have gone out, in some of our sectors we are not calling it a stimulus package; we are calling it a 'stimulants' package because, as I say, a number of people—

CHAIR: Professor Emmerson, I am sorry to pull you up. Can I please ask whoever is on screen to mute your mics when we have speakers talking because we are getting a lot of echo.

I think, Professor Emmerson, the point of border closures is keeping Queenslanders safe from COVID-19 and putting their welfare first. I do not know if you want to close off on any comments around that.

Prof. Emmerson: That is a delicate balancing act. If we were to go like Victoria then it would be, in my view, a far greater disaster from a health point of view and it would have an economic impact as well. I understand why the borders may need to be shut for a period of time while there is active community transmission in either Victoria or New South Wales.

CHAIR: It is perhaps best summarised this way: you cannot have an economy if you do not have your health.

Prof. Emmerson: Correct.

CHAIR: Thank you very much to both the Alliance for Mental Health and the college. We are out of time. We will ask our next speakers to come forward. Thank you for putting up with some technical challenges.

BROOKE, Mr Mark, Chief Executive Officer, Lung Foundation of Australia

CARTWRIGHT, Ms Angela, Policy and Advocacy Manager, Asthma Australia (via videoconference)

GOLDMAN, Ms Michele, Chief Executive Officer, Asthma Australia (via videoconference)

SCHLUTER, Ms Patricia, Advocacy and Policy Manager, Lung Foundation Australia

CHAIR: I might ask the Lung Foundation Australia representatives to make an opening statement while we sort out the audio for the other people who are here.

Mr Brooke: Our statement will probably be in three parts: a little bit about the foundation and the impact of COVID-19 on older Australians living with lung disease; the government's response; and finally a little bit of futureproofing around what we see as some of the emerging evidence around COVID-19 and lung health more broadly.

The Lung Foundation is a national charity based out of Brisbane. That is why we are here today: we do not have to travel across borders. The Lung Foundation is governed by a board of world-leading respiratory clinicians, and we are in a very fortunate position to be guided by respiratory evidence not just within Australia but globally. I tender my apologies for Professor Christine Jenkins, our chair. She is a frontline health worker at Concord hospital in New South Wales.

It is fair to say that after the bushfire emergencies the Lung Foundation was already experiencing a significant surge in demand for our inquiries line, our 1800 health line. At the beginning of February right through to today we have seen a significant increase—almost a 600 per cent increase—in the number of Australians with lung disease seeking tailored information about COVID and their disease. That information ranges from what many of the other organisations have given evidence on: the wearing of masks; specific information about telehealth; working; and the impacts or side-effects of COVID-19 on a particular lung disease. It is fair to say that the Lung Foundation has never experienced the demand that it has now. The increase on our 1800 service is documented in the survey that we tabled today.

We are incredibly grateful—and we make this point willingly—to the Queensland government for its one-off funding support to enable that service to meet that surge. We would also probably acknowledge that the Queensland government was the only government in Australia to fund our organisation at our time of greatest crisis. We wrote to the federal and every other state and territory government, and it was only Queensland with its $200,000 one-off grant that enabled the Lung Foundation to meet the challenges we currently face.

In terms of the impact on older Australians, in context one in three Australians will have some form of respiratory illness across their life. At the moment, lung diseases and lung cancer are three of the top five causes of death for every Australian over the age of 45. The mortality from lung cancer, chronic obstructive pulmonary disease, or emphysema, as well as pneumonia and influenza account for those top causes of death. Quite literally, the Lung Foundation was able to rapidly deploy evidence based tailored information to consumers. You will see in the survey we provided that that information is not just valued but also highly trusted because it was tailored. We make the comment that general community information around COVID-19—social distancing, washing your hands et cetera—is great in the broader community context, but those living with a lung disease who are the most vulnerable in terms of COVID-19, wanted—and indeed, insisted upon—more tailored, specific advice to the point where the foundation produced a whole range of resources and was very agile in changing all of our face-to-face programs to virtual programs.

I may possibly contradict a previous speaker. I have to say that our older community rallied around the use of technology very, very quickly. We operate over 900 Lungs in Action groups right across Australia. They moved to virtual exercise programs. We have over 700 support groups throughout Australia. They moved in the large majority of cases to virtual and telephone support groups. The reason that older Australians wanted to do that, although it took some tutoring in the first instance, is the connectedness of older Australians. It is incredibly important, particularly where they have lung disease, and living with a lung disease or lung cancer is incredibly isolating.

Looking forward, we think there are several key points that are pertinent to this committee. First and foremost is that during the last six months the number of diagnoses for lung cancer in particular has dropped by nearly 50 per cent, so referrals to specialist centres. People withdrew from usual care and the diagnosis of serious conditions such as lung disease or rare lung diseases substantially

declined. That will put increased pressure on health systems right across the country but also here in Queensland. Emerging evidence from overseas is that people who have had COVID-19 are prone and susceptible to long-term lung damage, in particular a disease called pulmonary fibrosis. Pulmonary fibrosis is a terminal illness. Whilst COVID may kill a range of Australians, sadly, right now, we believe there will be a substantial flow through in terms of pulmonary fibrosis over the next five to 10 years.

The other point we would make—and it is a point that we think is really important in the context of pandemic research going forward—is that, if you think about lung disease as a totality, it accounts for nine per cent of Australia's health burden but it receives only two per cent of research funding. It is going to be incredibly critical in the next five to 10 years that that imbalance is addressed. We do not think that is just a job for the Commonwealth. We think that there needs to be a coalition of state, territory and Commonwealth governments all investing in research.

Finally, I would just make a comment about telehealth. Telehealth was rolled out remarkably quickly. I think is a world-leading example of how Australia was very agile in meeting the needs of patients, but for people with lung disease it is part of an answer. There has to be a blended approach. It is very difficult to do spirometry via a television screen. Older Australians will warm to it, but it needs to be considered as part of a continuum of care and not just substituted as a low-cost base for delivering services.

I will finish up on that note. I cannot see if my colleagues from Asthma Australia are behind me or not.

CHAIR: They are. Speaking of lungs—thank you very much, Mr Brooke, for that; I will come back to you—I will maybe just plant the seed now around the topic of pulmonary fibrosis and whether there is some gathering evidence internationally. I will leave that with you for now. Ms Goldman, would you like to make an opening statement?

Ms Goldman: We really appreciate the opportunity to speak to you today and represent the experience of people with asthma. Asthma Australia, for those who may not know us, is a for-purpose consumer organisation. We have been working to improve the lives of people with asthma since 1962.

Asthma affects one in nine Australians. It is an inflammatory condition of the airways and it restricts airflow. It can be fatal. Sadly, some 400 Australians still lose their lives to asthma each year. It is considered that 70 per cent of those deaths could be avoidable. There is no cure currently, but most people with asthma can experience good control with good management. Our purpose is to help people breathe so they can live freely. The burden of the disease is significant and it impacts on all aspects of people's lives.

Firstly, and following Mark's comments, I would like to commend the Queensland government on its response so far to the COVID-19 pandemic, which has seen a significant stretch of time without community transmission. I would like to note that the COVID-19 pandemic is ongoing, and I think recent events in New Zealand remind us that we all need to remain vigilant. As the pandemic unfolds the impact on the community is changing, and we will share some of the insights we have for people with asthma with regard to that. So too should government responses. Whilst we welcome efforts to learn as we go, we want thorough reviews to take place once the pandemic is controlled to reflect, learn lessons and ensure we can be better prepared for what will inevitably be future respiratory pandemics. That is why our overarching recommendation is that, once we are in the recovery phase of the pandemic, a national steering committee be established and that its role will be to review existing pandemic plans, investigate any areas for improvement and build on the existing plans to create a comprehensive national pandemic preparedness plan.

Back in April Asthma Australia launched an asthma and COVID-19 survey which sought to understand the experiences of people with asthma and to inform our public information and advocacy around the pandemic. We received over 1,800 responses, 14 per cent of which were from Queensland. Following this survey we got a smaller cohort of about 300 to 500 people who agreed to complete a regular Pulse survey and that aimed to help us track how issues were changing and impacts and sentiments over the course of COVID-19 which has been extremely valuable. I will share some of the key findings from these surveys and am more than happy to provide the survey reports to the committee if there is interest.

The overwhelming finding from all of our surveys was that people with asthma report a heightened experience of anxiety in response to COVID-19, obviously with it being a respiratory pandemic and asthma being a respiratory disease. In our initial survey more than half of participants rated their anxiety about COVID-19 as six or higher—and that is on a scale of nought to 10—and one

in five people rated their level of anxiety as a nine or a 10. Significantly, one-quarter of respondents said feelings of anxiety, stress and depression had been triggering their asthma. Two-thirds of people with asthma reported they were self-isolating and we believe this is much higher than would be necessary on medical grounds, so I think it relates to the additional risk that people with asthma perceive they have as a result of having asthma.

In our April survey one-quarter of people with asthma had faced challenges accessing their usual medication. Thankfully that number has come down in subsequent surveys. Finally, people with asthma experienced changes to their usual health care during COVID-19, with one-third of people with asthma reporting concern about COVID-19 exposure at health services and nearly one in 10 being unable to see their GP in person. Our most recent survey has focused on the experiences of people with asthma and face masks, so once again I am happy to share findings with the committee if there is interest.

CHAIR: Thank you very much, Michele, and I think the committee would appreciate any data on those surveys that you have. I thank both organisations—the Lung Foundation and Asthma Australia—for the work that you are doing. Clearly these are vulnerable people during COVID-19. As you have both indicated from your surveys, there is a heightened risk of getting the disease and of course the ongoing complications. Whether it is COPD, COAD, emphysema or asthma itself, these people are at a great risk. I was interested to hear you talk about a steering committee post COVID, Michele, but I also noted, Mr Brooke, that you started a COVID-19 steering committee back in February 2020. Is there collaboration between the two groups on COVID to a degree?

Mr Brooke: Yes. We work as part of a multidisciplinary organisation called the Lung Health Alliance which includes Cystic Fibrosis, Asthma Australia, ourselves and the Thoracic Society of Australia and New Zealand and we have continued to meet as CEOs right the way through this but also across the cancer space. Cancer Council Australia also convened all of the cancer organisations, so I represent the Lung Health Alliance on that group as well. I have to say that our sector—the respiratory sector—is incredibly collegiate, so we try not to duplicate or waste taxpayers' or community donations and the organisations have worked together and are working together right now on a dedicated respiratory research mission that we are putting to the federal minister, Greg Hunt.

CHAIR: From your experience and your surveys about the increased anxiety, just how important is it for those borders to be closed to reduce risk of community transmission in Queensland?

Ms Goldman: We have not had anything specifically pertaining to fears about people coming in from different territories. I think the big concerns for our constituents—the one in nine people with asthma—pertain to being able to access medical care safely in the early stages of the pandemic, especially for people with severe asthma who rely on outpatient services. Those resources were being redirected towards being prepared for COVID and there had not been any planning. There were severe concerns around how these people were going to be able to access their biologic medication treatments, so access to medication has been a big concern. Masks have been the most recent concern. Obviously now that is mandatory in Victoria and there are conversations happening in New South Wales. Our surveys show that many people believe that masks are protective and should be worn, but there is a percentage of them for which it creates greater anxiety if they wear a mask and it can trigger an asthma flare-up. Those are the kinds of issues that our constituents are talking about and the issue of the borders has not come up.

CHAIR: Okay. Mr Brooke or Ms Schluter?

Ms Schluter: When it comes to the borders, I would highlight the conclusion to our survey. When we asked our members and supporters what they wanted to see change for the better as a result of COVID, the No. 1 result was they wanted better health screening at the borders. A lot of the written comments we had from the people who were surveyed were very strong on closing the national border and they have been consistent about keeping very tight and close borders in Queensland to maintain our gains, essentially.

Mr Brooke: There is possibly one exception to that, and that is within the lung cancer community living in border communities themselves who need to travel to a tertiary centre for care, and the inconvenience or the delays in that care we have seen played out within the Victoria-New South Wales border towns of Albury-Wodonga. Whilst we have not had any specific commentary around the Queensland borders, we would make as a general point that a lot of tertiary centres on border communities rely on each other, so being able to easily access care cross-border is incredibly important to particularly patients with severe lung disease and/or lung cancer.

CHAIR: Thank you very much.

Ms PEASE: Thank you for the great work that you are doing. I was very interested to hear about the 1800 phone line that you have operating and I am wondering if you can provide me with some advice about the type of people who you have manning the hotline.

Mr Brooke: It is staffed by a mix of nurses, so we have dedicated specialist nurses, including respiratory nurses and oncology nurses for lung cancer patients, and we have a team of population health graduates that do the preliminary triaging/screening follow-up calls. It is not just a telehealth service; it also has a texting service, and I heard the previous evidence around the impact of texting. I guess this is a reflection of a small percentage of our community, but some still require—do not have any access to social media or email—our teams to get around a board table and pack fact sheets into envelopes which happened on a fortnightly basis and is continuing to happen for about 400 Queenslanders who do not have access to email.

Ms PEASE: That is across the board; I am very much aware of that in my electorate. That is exactly what we are finding. One of the things that I would like to understand is the types of referrals. Are you getting people who are being referred to go off and get COVID tested or people who have tested positive with COVID and are wanting information, or is it just a general awareness of the requirements?

Mr Brooke: No. We have only spoken to three patients who have been identified or diagnosed with COVID. We have spoken to a number of family members who have patients who are recovering, but the vast majority of the people who call our number are patients living with very complex lung diseases who are after much more tailored information than hand washing or who say, 'I can't get in to see my specialist,' or 'I'm not able to attend a pulmonary rehab clinic at the moment. What should I do?' To give you a definitive statistic, our call time is normally 20 minutes per patient; it has blown out to 55 minutes per patient because it takes a lot more time to unpack that. As of today, there is still a four-week waiting list for us to call you back.

Ms PEASE: That is amazing. Thank you for your great work. Finally, I would like to hear more about pulmonary fibrosis. It is a bit frightening.

Mr Brooke: Pulmonary fibrosis is the scarring of the lungs. It is without a cure and generally is a disease that impacts people over the age of 60. What we are seeing out of evidence from Europe, which is significantly into a second wave, is that many of those patients who have recovered have significant scarring to their lungs and that is the first indicator of pulmonary fibrosis, and we would make the point that the Lung Foundation hosts the national registry for pulmonary fibrosis patients and we currently are tracking about 1,700 patients in that regard. The clinicians through the centre of research excellence based here in Australia who look after pulmonary fibrosis and interstitial lung disease, which is the broader category, are indicating to us that they may see between a 10 per cent and a 15 per cent increase in IPF and PF patients over the next five years. To put that in context, that is about 4½ thousand Australians who may develop pulmonary fibrosis, and that is an incurable and terminal illness.

Ms PEASE: I want to go back to the call centre again or the online service. That service is Australia-wide. It is available to every person in Australia, but it is only currently funded by the Queensland government?

Mr Brooke: Correct.

Ms PEASE: Has there been any indication that the federal government or other jurisdictions might be prepared to put some money on the table for that?

Mr Brooke: No. The federal government's reply to us was that they were confident with their existing systems of general messaging to the community.

Ms PEASE: Thank you very much for that.

Mr BERKMAN: Further to the question about pulmonary fibrosis, what does the emerging evidence suggest about other lung disease and those longer term risks associated with having contracted and recovered from COVID-19? Beyond that, I am interested in the context of what appears to be a pretty drastic shortfall in research funding for lung disease more broadly. How should research funding for those longer term ramifications of COVID-19 be focused around lung disease?

Mr Brooke: The short answer is that we commissioned PwC to do a retrospective analysis of burden of disease and then research investment both at a federal and a state level, so we know that those numbers are rock solid. The burden is nine per cent and the investment is two per cent. That burden will substantially increase as a consequence of COVID-19. It gives us no joy to say that we are about to knock off the Heart Foundation as the leading cause of death in Australia within the next five years. There is no joy in that, but that is the reality. If you look at the way in which research

expenditure is allocated in this country, cardiovascular health has a $220 million medical research fund mission yet lung health does not. One of the things that the Lung Health Alliance and Asthma Australia and the Lung Foundation are very clear about is addressing that imbalance, and that is both at a federal and a state level. We do not think the feds just have to carry all of this load. One of the great opportunities of this has been to work more collaboratively across government, but certainly we will be submitting as part of our own advocacy a redress or a national medical research dedicated future fund looking specifically at respiratory illness which will have a COVID-19 tail stream—that is, what will be the impact on lung health over the next five to 10 years?

Mr BERKMAN: Just quickly in the time remaining, which is very short, are there other conditions that you can just flag for us beyond pulmonary fibrosis that have been identified as being affected or longer term consequences post COVID-19 recovery?

Mr Brooke: I think there is a range of evidence around other cardiovascular diseases, such as swelling of the muscles around the heart. There is certainly evidence around mental health and anxiety, which you have heard from previous speakers, which are not physical, but clearly there are mental health and disabilities that are going to arise from this.

One of the things that we remain most concerned about is the unknown. Because idiopathic pulmonary fibrosis is not well known in the community, we actually do not know how many Australians have that disease or indeed how many Australians will develop long-term lung disease as a consequence of what has been a very long—we are talking about the bushfires as a distant memory. It was only seven months ago when most of Australians' lung health was directly impacted. We are yet to see the consequences of bushfires on lung health, never mind now a respiratory pandemic.

The short answer is we simply do not know what that long tail would be, but we do not want to wait five years arguing about research funding to then get caught with our pants down and have a whole range of patients appearing before respiratory specialists. We need to know now.

CHAIR: Michele, in your submission you recommend funding for telehealth that is due to expire in September becomes permanent and options for care for people with asthma are expanded. I know you made the point that spirometry cannot be done on a screen. How important is it that this funding is continued for continuity of care?

Ms Goldman: I would make the point that all the surveys we have done have made really clear people's concerns and challenges in being able to access medical care. I think a big problem during the pandemic—and it is much broader than just respiratory diseases—is continuity of care and people delaying care in terms of tending to a whole range of chronic diseases. The thing with chronic disease is it requires ongoing care and management, otherwise it deteriorates and it can result in a whole host of other things.

We need to ensure that people can continue to access care, and telehealth is critically important, especially at a time when their symptoms—asthma has a range of different symptoms, one of which is a cough. Unfortunately, for many people with asthma their cough is perceived to be COVID. When they are out and about they are being vilified for coughing in public spaces when it is just their asthma cough. When they go and see their doctor one of the first questions they are asked is, 'Have you had any symptoms?', and they are saying, 'Yes, I've got a cough. It's my asthma cough.' They are then told, 'You need to go and get tested.' In that environment being able to access care via telehealth is critical.

CHAIR: Thank you very much. That is well articulated. That is a good response to that question. We are out of time. I thank Asthma Australia. If you can provide any evidence around pulmonary fibrosis that would be of great assistance to the committee. We thank the Lung Foundation for being here today. We will take a short break and recommence at 10.50 am.

Proceedings suspended from 10.33 am to 10.50 am.

CARROLL, Commissioner Katarina, Commissioner, Queensland Police Service

CHELEPY, Assistant Commissioner Shane, Operations Commander COVID-19, Queensland Police Service

GOLLSCHEWSKI, Deputy Commissioner Stephan, State Disaster Coordinator, Queensland Police Service

YOUNG, Dr Jeannette PSM, Chief Health Officer, Queensland Health

CHAIR: Good morning and welcome to Dr Jeannette Young, our Chief Health Officer, as well as Katarina Carroll, Commissioner, Queensland Police Service and other witnesses. Dr Young, would you like to make an opening statement before we move to questions?

Dr Young: Thank you for this opportunity. It is great to be able to come and brief the committee again. First, I would like to acknowledge the traditional owners of the land upon which this parliament is, the Turrbal and Jagera people, and pay my respects to elders past, present and emerging. I would also like to take note of the fantastic leadership that remote First Nation communities have had in Queensland. To not have had a single case in any of those communities is a real testament to the leadership of the mayors in those communities and the elders.

Thank you very much for the opportunity to give a very brief opening statement about the ongoing health response to COVID-19 in our state of Queensland. I would first like to start by addressing the current situation in Queensland. In absolute terms, the rate of growth of new cases remains low, with only three new cases in the past fortnight ending 18 August despite more than 158,000 Queenslanders coming forward and getting tested. It has now been 18 days since the last known case was infectious in the community.

These latest cases bring our total to 1,092, with six of those being active and three of those active cases currently receiving hospital treatment. To date, unfortunately, six Queenslanders have died of COVID-19. Again, of course I want to extend my deepest sympathies to their families. There have been no reported deaths from COVID-19 in Queensland since I last addressed this committee on 23 June, and Queensland continues to report one of the lowest rates in terms of number of cases per capita around the world. That is due, I firmly believe, to the efforts of Queenslanders in which they have adhered to extremely draconian restrictions on their normal way of life.

The pandemic, unfortunately, continues to accelerate exponentially around the world, so therefore we cannot be complacent. This is still the start of the pandemic. We have a long way to go, unfortunately. Today more than 22 million cases of COVID-19 have been reported across the world. That is more than double the number of cases I reported only eight weeks ago, on 23 June. Sadly, more than 778,000 people have lost their lives due to COVID-19.

As you know, Australia has not been immune to the impact of COVID-19 in recent months. Victoria is now in its third week of stage 4 restrictions across all of metropolitan Melbourne, including a curfew, school closures, closure of all non-essential businesses and significant movement restrictions. The remainder of Victoria is under stage 3 restrictions and all Victorians, no matter where they live, must wear a face covering when they leave home.

Over the past week Victoria has reported 2,002 new cases of COVID-19 and, sadly, yet again today, they had to report 12 more deaths, bringing the state's total to 363. The situation in Victoria has had a significant health impact on their own population but also across Australia. We have had to work with them and support them, and of course we will always do that. It has also meant that we have had to look at what we need to do in Queensland as a result. We have then seen multiple clusters emerge in New South Wales over the past few weeks, with 82 reported cases over the past week of which the vast majority were locally acquired.

Given the devastating impact COVID-19 has had on the health and livelihoods of Victorians, culminating in that terrible loss of life, particularly across residential aged-care facilities, it is absolutely vital that we continue to do all the work we have done in Queensland to stop a resurgence of the virus happening here in Queensland and the restrictions that would inevitably have to be put in place.

The decisions to reimpose border restrictions on Victoria and then subsequently New South Wales and the Australian Capital Territory were not taken lightly—of course not—but limiting people's ability to enter Queensland from a place where the virus is more prevalent remains probably our most effective protection as we go forward. We have endeavoured to strike a balance between protecting

Queenslanders and minimising the impact on people, whether that be social impacts or economic impacts. We are in a continual process of finetuning our restrictions to ensure they are responsive to the situation at hand and are able to be adapted to rapidly changing conditions.

I thought I would mention very briefly what we might expect to see going forward. I believe—and experts believe—that there are four conceivable ways out of this pandemic: natural herd immunity, the virus mutating to become less contagious or less severe, effective treatments, or a vaccine. All Australian jurisdictions have rejected the natural herd immunity approach from day one of this pandemic as we knew the cost would be devastating in terms of lives lost. There is now considerable evidence that the virus that causes COVID-19, SARS-CoV-2, is not mutating to become less infectious. It is mutating—viruses do—but its characteristics are remaining the same.

There are several treatments for COVID-19 that are currently being explored by researchers across the world and clinicians are looking at currently available treatments and therapeutics, and some of them have shown some great promise. This includes medication already being used to treat other diseases such as dexamethasone and remdesivir; convalescent plasma therapy, which involves giving people with severe symptoms, severe disease, convalescent plasma from recovered patients to boost their ability to fight the virus; and then there are some new antiviral medications in the pipeline. That is all encouraging.

There is also—and I am sure you would have seen the media today—increasing optimism about the viability of a COVID-19 vaccine. There are currently over 160 candidates in development worldwide and some have entered human trials, including here at the University of Queensland. Having said that, we do of course need to be realistic that if—and hopefully when—a vaccine candidate is proven to be suitable, effective and appropriate, it is a massive task to scale that vaccine production to population-wide levels. A lot of work has already started in that space. I think we should be hopeful that a vaccine will be developed, but realistically we also need to expect to be fighting COVID-19 without one for potentially the next 12 months and possibly longer. Until we have a vaccine, our best defence will still be to slow the spread of the virus through all of the strategies we have done to date, in particular physical distancing, good hygiene and testing people as soon as they might have it.

As you would be aware—and having my police colleagues here shows—Queensland Health is only one small part of a massive government response. I do want to acknowledge the response from police. They were involved from day one in Queensland, and I think that has made the big difference in Queensland compared to some of the outcomes we have seen in other states. I think our police are here for law and order but also for welfare reasons, and they do that so effectively in Queensland.

I want to acknowledge colleagues across the whole of government who have stood up and provided support. Often I do not know about it until I think of something and then someone says, 'No, we did that a long time ago.' It has been brilliant to see. I think to date Queensland has done remarkably well to proactively respond to COVID-19. Without that very proactive action we would not be where we are today, but we do still have a long road ahead. I hope it is shorter, but I expect it might be a bit longer. If we continue to show the same determination that we have shown to date, I believe we will manage it successfully. Thank you very much, Chair and committee members.

CHAIR: Thank you very much, Dr Young. I know you are going to say, no, it is the Queenslanders who did it and, yes, we should be thanking everyone for their efforts to date. However, on behalf of the committee, I thank you for the work you have done in leading us. This is enormous and leading the health response must be a significant burden. We know that you now have a Deputy Chief Health Officer to assist, but you have been at the forefront. We thank you for your work and we thank all involved across government, including in Queensland Health.

That was an excellent segue to the Queensland Police Service and Commissioner Katarina Carroll. Welcome. I pass on our thanks to the Queensland police for your enormous efforts at border control. In her opening statement, Dr Young mentioned remote and Indigenous communities. This committee was up in the Torres Strait just last week. In fact, at Saibai we saw Queensland Police Service staff with border patrols and air defence working together to make sure that our most-at-risk communities are kept safe. We thank you for the work that you do. I welcome Katarina Carroll, the Commissioner of the Queensland Police Service, to make an opening statement.

Commissioner Carroll: Committee Chair and committee members, I sincerely thank you for allowing me to make an opening statement. I too would like to start by acknowledging the Indigenous peoples of the land on which we meet and honour their elders past, present and emerging.

As you would know, the primary response to the public health emergency in relation to the coronavirus in Queensland has been a public health and safety response led by Queensland Health. Our role is to support the response within the Queensland disaster management arrangements. The disaster management arrangements involve a whole-of-government led response, led by the State Disaster Coordinator reporting directly to the Queensland Disaster Management Committee.

The QPS established Task Force Sierra Linnet within the State Police Operations Centre to prepare, plan and coordinate the QPS's contribution to the whole-of-government COVID-19 response. The QPS's role in relation to COVID-19 has focused on providing support to Queensland Health through undertaking compliance activities for the public health measures implemented to contain and respond to the spread of COVID-19 in Queensland.

My staff, particularly the two beside me, lead not only the whole-of-government response but also the internal response in the Queensland Police Service. This was a very important decision early in the response to this pandemic to ensure that there were no gaps between the response externally and internally. Obviously, they are very much across what is happening across all of government and not just within the QPS.

The operation of the State Police Operations Centre, known as the SPOC, required the allocation and relocation of significant policing resources to undertake a multitude of functions in facilitating the QPS's response to COVID-19, including the following discrete cells that actually deal with this: planning, strategy, command, legal, information, investigations, administration, logistics and intelligence. The QPS redeploys up to 1,200 to 1,300 staff a day—depending on what is happening in terms of this—from policing functions and corporate functions to duties associated with the COVID-19 response across the state, sometimes at very short notice, to implement various public health measures associated with the emergency. The QPS has also agreed to appoint all approximately 12,000 police officers as emergency officers general under the Public Health Act 2005 and assume responsibility for the delivery of emergency officer general roles, such as the service of quarantine notices at Queensland borders, including state and international.

The extensive and ongoing QPS contribution to the Queensland government's COVID-19 response is compiled of the following—and I do not think some people realise the breadth of it until I actually state it: the SPOC, Queensland state controlled border points, international and domestic airports, quarantine hotels and accommodation facilities, district operations centres, vehicle checkpoints, district disaster coordinators and coordination centres, support at entry points for designated areas declared under the Biosecurity Act 2015 and obviously the patrols of general businesses in terms of compliance as well.

The QPS has led the whole-of-government planning across a broad range of disaster management issues through its legislative responsibilities in disaster management governance, which include the appointment of police officers as state disaster coordinators and also district disaster coordinators and the command—and I have touched on this—of the State Disaster Coordination Centre and the chair of the State Disaster Coordination Group. For example, some of the other work is the state rapid response plans, the state mortuary surge plan, the air travel reception planning, the state border closures and, as was touched on, the remote community border closure planning.

The disaster management arrangements were also used to activate a range of support from the Australian Defence Force, which has provided significant commitments to operationalise our borders in particular but across the entire gamut. The disaster management arrangements have also been instrumental in ensuring a coordinated whole-of-government approach to supporting and planning engagement, particularly in our remote communities that are deemed the most vulnerable to the pandemic.

Lastly, I want to say from the very outset that, in what has been an extraordinarily challenging environment, our strategy has been one largely of education through compassion, communication and—as we always say—where there has been blatant disregard then through compliance. A sincere thank you.

CHAIR: Our sincere thanks to you. That is enormous and touches on the broad impacts that this has had on the Queensland Police Service, from quarantine to checkpoints at borders. We hear the deputy commissioner on the news talking about the hundreds of thousands of vehicles that are coming through and that the ones that do not have passes are turned away, which is for good reason: to keep community transmission away from Queensland. I know that is one of the key points for Dr Jeannette Young.

Dr Young, I take you back to your opening statement. You talked about the four things for 'what next': herd immunity—no, the virus itself mutating, various treatments and the vaccine. I want to touch on that, because a lot of work is going on in that space, including here in Queensland led by our University of Queensland. We also know of the recent announcement of a trial of COVID testing by Queensland pharmacies. I am very interested in this. If we ever land a vaccine—and I hope we do—it would be great if it is another Queensland first. We need to be able to deploy it far and wide to the five million people of our state and then, obviously, of other states and territories as well. How do we do that? Do we strengthen our response by utilising the pharmacy network? I am very interested in the benefits the department will hopefully gain by allowing pharmacies to conduct COVID testing. Are there plans in place so that, should a vaccine be delivered in Queensland, we can get it to the people of Queensland?

Dr Young: I will address the vaccine issue first. We have already had discussions with the Pharmacy Guild about rolling out the vaccine through community pharmacies throughout the state. We have had quite a few years now of a very successful flu vaccination program being delivered by community pharmacies. We need to wait and make sure that we know what the vaccine is and any issues with its delivery or its storage—anything like that—but I would hope that all of our community pharmacies would be able to deliver it.

Not all community pharmacies have participated in the flu vaccine delivery process. I have spoken to the guild to ask, if it were possible, if they could get all community pharmacies to do the necessary training and preparation to be able to do it. There are requirements for pharmacies that they have to have—physical and environmental requirements as well as storage requirements and training requirements. It is not a simple thing for a community pharmacy to vaccinate, but I would like to, wherever possible, have that occur. We know that there are community pharmacies in nearly every single community in Queensland, so it is a very quick way of being able to get out to as many people as possible.

During the last pandemic we stood up school clinics, but that was harder because you then have to go and organise all of those additional staff. We probably will have pop-up clinics to vaccinate, but I think our main strategy will be to use those places that currently vaccinate—community clinics, which some local governments run for instance, health services of course run them and GPs run them. We will take all of our current processes, use them and enhance them, rather than creating a brand-new process. That is the plan at this stage. We have done quite a bit of work for that.

On the second question, we are planning a pilot trial to see whether community pharmacies can actually test people for COVID. We know that people do visit their community pharmacy when they have a cough or a cold or mild symptoms and they seek advice. We would like the opportunity—this is what we want to trial—to see whether that would mean that we get more people tested.

It is people with symptoms who are the most concerning. We know that around 20 per cent of people can get this infection and not develop symptoms ever. We know there is that group. However, the vast majority of people will have symptoms. They are the ones we really want to get in and test, rather than people without symptoms. We do not have cases in Queensland, so it would not make sense to test people without symptoms. We really want to test every single person with symptoms. We know there are still people with very mild symptoms who do not consider that they might have COVID, but they often go to their local community pharmacy where they know the pharmacist and they have a relationship. That is why we think it would be useful to add that in as an extra benefit to the testing process in Queensland. At this stage it is a pilot. We will see how that works and see if there are any issues with it.

CHAIR: Thank you very much for that. My next question is in relation to what is going on in Auckland, New Zealand. They had 100 days without any cases after a stage 4 lockdown. There have been some media reports, although I do not know if we can rely on them for accuracy, on how the cases started. There were also recent media reports around the importing of frozen foods. Can you make any comments on that? Can we reassure people that testing is being done at borders for all types of things?

Dr Young: It will have been contracted from humans. It is humans who carry the virus. It is very, very, very unlikely that food, with the time it takes to travel, would continue to have viable virus on it. That is extremely unlikely. It is people. Although they have not had any community cases, which has been a fantastic outcome, in New Zealand for over 100 days, they have had people come into their quarantine hotels and also come in through their ports with the virus. It will have been acquired through one of those routes.

CHAIR: The issue of PPE came up with various submitters, including the GP network and I think we have articulated that the PHN was looking after them. I think it was only yesterday that I saw the Premier in a massive facility at Inala with pallets of PPE. I believe that the Queensland government commissioned KPMG to complete a report that reviewed PPE requirements across the primary and acute health sectors. You may take this one on notice, but have there been any findings from that review to date?

Dr Young: I am sorry, I do not know the details of that report, but I do know the outcome. We now have enormous stocks of PPE. We will not run out. We have plenty. There will be no situation in Queensland, no matter how many cases we had—and I desperately hope we do not have the cases—where we would not have the PPE that is needed. We do not just have that one storage facility that was seen yesterday, we have multiple because, of course, you do not want to put all of your equipment into one place and risk losing that whole facility so we have multiple. We have plenty of PPE going forward. Indeed, PPE is now being produced here in Brisbane, which is even better. There is no risk of people working in Queensland in the primary healthcare sector or in the NDIS sector or in the aged-care sector running out of PPE. They can acquire that PPE very easily.

CHAIR: Thank you very much. I will open up to questions and start with the member for Lytton.

Ms PEASE: Thank you so much for coming in. I would like to acknowledge Dr Jeannette Young and the great work that you and your team have done but also Commissioner Carroll. Thank you very much to all of your team. I know how hard you have all been working. I have got some great local police officers. Senior Sergeant Wayne Richter at Wynnum is doing a great job. I remember Shane from when he used to be at Wynnum. We are well represented here so thank you.

One of the questions that I have is around PPE in the aged-care sector. What sort of training is given to people working in the aged-care sector who have not necessarily or have never experienced using PPE? Who is required to train those workers in how to use that?

Dr Young: Recently we did some online training. I got to open that and it was great to see the engagement from all of the aged-care sector and then we have organised face-to-face training in different ways. Then the most important thing, although that training is very, very important—it is even more important— is if you get a case, to go into that facility with the infection control experts to train people again, so on-the-spot training. We also have an agreement with the Commonwealth, which is excellent. We provide the first three days of PPE that an aged-care facility needs, and we have actually put that out there across the state, and after that the Commonwealth will replace any PPE that is needed but we actually have plenty of PPE now in the state so we could manage it indefinitely.

Queensland Health has given a guarantee to every aged-care facility in the state that if any of their residents gets COVID-19 we will immediately move them out of that facility into a local hospital or, if the local hospital is not suitable because it is a very small one, we will move them to a larger hospital. Of course, in health nothing is ever absolute. We would work that through. If the person was unfortunately dying and was only going to be there for a short time we would protect them within that aged-care facility and protect the other residents, but the aim essentially is to move people out and we have done that in consultation, of course, with the aged-care sector to make sure that is what they would prefer. We have spoken to relatives and to the aged-care sector and essentially they would like that assurance that those people who are infected do not remain with all of the other people in that residence. No matter how good the PPE is, no matter how good the systems are, there is always a risk.

Ms PEASE: My next question is to Commissioner Carroll. With regard to the state disaster coordination team, how effective has that been in our response? We are a state of natural disasters so we are used to coming together and working as whole-of-government. Has that really contributed to our great response?

Commissioner Carroll: I think Jeannette could answer this one as well. The reason I say that is because the team has been together for an extended period of time. The arrangements are extraordinarily robust and well proven. What would normally happen is that it is generated from the bottom up. You have a disaster at the local level, the local committee is chaired by the mayor and once they do not have capacity to deal with it anymore it then goes to a district level which is chaired by a superintendent of police. Once they do not have the capacity it then goes to the state and is led by the State Disaster Coordinator who reports to the QDMC. It is an extraordinary framework in terms of everyone within the framework knows what their role is and is well practised at it because we have used in it the past.

Interestingly, we have used it effectively but in a very different way. What we have done this time round is pushed the requirements from the top down. I would say initially, and Steve might want to comment on this, it was a challenge because it was actually a different way of doing business.

However, the framework is extraordinarily sturdy, the relationships are really well established and what we did have through this, we had an election where a lot of the mayors had changed over, but we also have a very good system in making sure that as soon as they come in they are trained in the arrangements. This time round I would say we went above and beyond to constantly engage with the mayors in terms of what had to be done at that local level.

So, you can do it bottom up, top down. It is proven to be very agile and very effective. In fact, and I think I should mention this, there is currently a Commonwealth inquiry into quarantine in hotels and they spent a lot of time looking at our arrangements in Queensland, as has the recent bushfire royal commission. The arrangements are proven time and time again.

Ms PEASE: Correct me if I am wrong, this unit that we have in Queensland is unique to Queensland? Nothing like this operates around the rest of Australia?

Commissioner Carroll: It is unique because everyone has a different system. Some are very complex. In fact, one of the confusing factors, and you will see this playing out in Victoria, is who is in charge, who gave what command when, whereas it is very, very clear in Queensland: you have a lead agency and you then have the QDMC, which obviously at the state level is Steve Gollschewski. He coordinates the whole-of-government response to assist the leading agency.

Ms PEASE: Thank you very much. I know there has been a lot of discussion around borders. I am sure that there will be other people asking questions around that topic. I understand how complex and difficult it has been for your officers so I would just like to acknowledge the great work that you are doing down there. I do know how difficult it has been so thank you for that contribution that you have made.

CHAIR: I did have one question before the member for Nicklin asks one and that is what role does the Queensland Police Service have in mandatory hotel quarantine?

Commissioner Carroll: We have the lead role. Literally we command every hotel and we purposely made that decision very, very early because we have the legislative authority to do things. When you are not a police officer you do not have that authority in many instances. From the very outset I have been very firm on the fact, with Jeannette, that we will take that lead role and even if we have others in the hotel to assist us, and we will have our protective services officers, we will have the ADF, you name it, Queensland police will always have command of each hotel. I think as of today we are up to 24, which has dramatically increased in recent weeks.

CHAIR: What kind of numbers do we have in mandatory hotel quarantine? You might like to take that on notice.

Commissioner Carroll: No, we will know. We will have that. We have a daily tally. Well over 3,000, I would suggest at this stage. An example is just on the weekend 756 in two days went into hotels.

Mr Gollschewski: It is 3,294 as of this morning in hotel quarantine and could I also acknowledge what the commissioner said and point out our whole-of-government approach gives us a unique relationship with the ADF as well. Through our disaster management arrangements Queensland has a very, very strong relationship with the ADF and they have been with us since the start so that has been really key in our response.

Mr HUNT: Commissioner, Dr Young and QPS representatives, I have had the chance to congratulate Dr Young previously, but not the QPS. As a proud member for 30 years before my election it has been great to see the QPS's excellent response once again to such a dynamic set of circumstances where resources are required to be deployed quickly and the environment changes quickly as well.

I want to direct my questioning around the QPS being the lead enforcement agency, around the Chief Health Officer's directives and how they change regularly and the training et cetera and communication to the Police Service. Certainly in the electoral offices we saw a lot of confusion around the definition of 'essential business activity or undertaking'. The definition of 'essential business activity or undertaking' was taken by the general community to mean its ordinary everyday meaning and a judgement of 'essential' in that respect. However, the meaning of 'essential business activity or undertaking' was actually defined within the directive itself and meant a business not listed in the prohibited businesses or activity so it was quite specific in what was meant by non-essential. I saw that confusion in the QPS as well. We were getting inquiries into our office of, 'Can I do this? Can I do that?', and we were seeking clarification from the local QPS around whether they would be fined for such activity et cetera and there seemed to be a little bit of confusion. We saw members of the QPS, for example, issuing fines for people attending a council waste facility which was not

included in the definition. I believe those fines were subsequently withdrawn. That was a long-winded preamble, however, the question is specifically related to what training instructions were provided to police that were required to enforce the Chief Health Officer's directives, what ongoing training is provided and how that is disseminated?

Commissioner Carroll: Thank you very much. I will make some opening comments and then I will obviously hand it over to Shane and Steve who run internally what happens at the State Police Operation Centre. From the very outset, I think we all have to know and admit that this is a very, very dynamic environment, changing constantly—in fact, sometimes hourly and sometimes on a daily basis. Those challenges are extraordinarily challenging from the outset. We have an internal system where we have legal people, training people, internal communications—we have recently implemented what is called Workplace but it actually is Facebook and we used it first for COVID-19. We have constant mechanisms, processes and systems that train people. However, we have never done anything like this in policing history. I think the last time we closed borders with police was in the 1918 pandemic so it really was a new role for police.

To your point, initially our strategy, because we were moving so quickly, was one of compassion, communication and compliance and I think that was lost in the first couple of days. That is why we brought an oversight into it where every PIN that was issued would be looked at. First of all at the deputy level and then myself and that is why you saw a number of PINs initially withdrawn. As the processes and systems improved, and as our strategy was also better communicated and actually went throughout the organisation, you saw a dramatic increase in that occurring. I just wanted to make those comments from the outset and I will pass it on to Shane who would have really the biggest oversight on what happens in our State Police Operation Centre and how we do that internally.

Assistant Commissioner Chelepy: In response to how that is operationalised, obviously the Police Service operationalises the direction that is produced by Queensland Health. We have a number of mechanisms for that. I have an operational legal team as well as an internal communications team within the State Police Operation Centre. We generate, for every change, very detailed aide-memoires out to all of our officers. We also run a 24/7 operational legal advice line and we have also introduced a bot online that is pre-programmed with all of our legal and operational enforcement questions. My engagement team also produce executive communication packs, officer-in-charge communication packs as well as district disaster coordination disaster packs.

For every change to CHO directions I personally lead briefings to all executive officers and all district disaster coordinators. Sometimes that is multiple times weekly. In some instances we have developed online training packages for very specific CHO directions, and we have used other resources as well, such as workplaces—the commissioner has indicated email—as well as personal briefings downwards then from the DDCs and the local officers in charge to all officers at our border checkpoints.

We also, as the commissioner indicated, have an ongoing review process. Every piece of enforcement action that is taken through a PIN is reviewed at first the district level now and then overviewed at Task Force Sierra Linnet. I also have a dedicated investigative cell of 36 investigators, led by a detective superintendent, to provide that support to officers 24/7 on the line.

I will note that we have withdrawn a number of police infringement notices. It currently stands, as of 31 May, at around 5.5 per cent of notices withdrawn. When we do that, as an overall comparison to our normal enforcement activity that we do day-to-day in policing, that is very comparative, if not on the low side. That is something that I monitor, as the commander, all the time because if I were to see that be an increased rate, I would know I would need to increase my communications.

Deputy Commissioner Gollschewski: This is a rapidly evolving environment. We have had to take an iterative process. It all comes to Dr Young's directions. Whilst they are a legal instrument, the whole point is stopping the spread of a virus. The approach we have taken with our officers is to reinforce that what we are about is not trying to catch and punish people, it is to stop the spread of a virus. As the commissioner said, if people are blatantly going to ignore the rules, we will take action. The educative process has been the way we have gone forward. What we have found is that the directions—I hate to think what version you are up to now, Jeannette—have had to evolve as the pandemic has evolved. We have got it to a very good point now where our officers understand what the overall intent is and we keep the information going. Communication is the key to this.

Commissioner Carroll: I also mention that we are taking this so seriously, obviously, and in the last couple of days I have decided that we will create a command, known at the moment as the COVID Command, purposely so that we will have permanent people in there with their own budget. At the moment, we are using staff and budget from other commands. This sends a strong message

internally that this is extraordinarily important for us and extraordinarily important for the community and we will have semi-permanent people there because we expect at least another several months of this. It is treated that seriously within the organisation.

Mr HUNT: My next question in relation to the percentage of enforcement notices that were withdrawn was answered—5.5 per cent and it is comparable. When you are enforcing the Chief Health Officer's directives, whilst it is important to be fair about it, it is important to be seen to be fair about it. One of the feedback matters we received from the community was in relation to protest activity. Specifically, the largest protest that was widely reported in the media, the Black Lives Matter protest, received some community backlash in terms of a lack of enforcement. If I ask questions that are operationally in confidence, just let me know. Was there an operational order done for that particular process? If so, were there any instructions given in that operational order to police on the ground in relation to enforcement activity or investigations or collection of evidence?

Commissioner Carroll: Yes, definitely. The operational orders are obviously written, but that is supported by all the briefings. With every one of these protests, we would have an ethos or a philosophy as to how we need to do business. This was a very difficult time in policing across the world; it still is currently. We knew from the evidence from across the world and even in Australia that we were not going to stop these protests. In fact, in other states they had taken the matters to court and had lost and the protests still occurred. Every jurisdiction across the world and in Australia took a different approach to this in what was a very, very difficult COVID environment.

From the outset, we had a strategy that we would discourage people from coming, and that was a message through the Premier and through our staff, 'Please do not come into the city to do this.' The other strategy was that we worked with the protest groups to get their own messaging out that, 'If you come in to the city, wear a mask, make sure you social distance,' et cetera, et cetera. That was also part of the strategy.

The next strategy was if we had tried everything, what do we then do to stop the spread of COVID-19? We ourselves made a decision that we would issue people masks. For us, as a policing organisation that was heavily subjected to what the protest was about, it was this balance of making sure that people could be heard over what was a passionate and extremely difficult issue in the community, knowing that COVID was out there, that ultimately if you did come out and march, that we would support you and we would give you this mask to make sure you did not spread it.

You cannot humanly, in any way possible, give out a PIN to that number of people in the streets of Brisbane. In fact, you would cause massive chaos and you would end up in an extraordinarily difficult situation. We met and strategised for days as to how we were going to do this. Interestingly, in South Australia, they were given a full exemption. Victoria probably did it similarly to what we did. In New South Wales, it was ultimately said that it was not going to happen, but obviously it still went ahead anyway.

All in all, when you think about the most challenging environment to have a protest, we went back and had a look at it and thought, 'Well, there were lessons from that.' However, we found ourselves in the situation that we probably would do it in a similar way again because we could not stop what was going to happen. I want to reiterate the added point that, as police, we were subjected to what the march was about, and that balance was incredibly important. I know we did get backlash, certainly, but I think the backlash would have been worse if we were handing out tens of thousands of PINs in what was a very delicate situation.

Mr HUNT: One follow-up question on that: was there any discussion held around perhaps fines issued or at least threatened to organisers of the protests to discourage them from going ahead?

Assistant Commissioner Chelepy: I can answer that. Yes, we did look at that. With protests like this, it is very difficult to identify the direct organisers because it is actually made up of multiple groups of conglomerate. Being able to take direct action against a specific organiser, which we looked at, was not possible on this occasion. However, on this occasion we used communication very strongly and we were very clear that any high-level disobedience or blatant disobedience we would take action on. I know we did take action on a number of criminal matters that came out of those protest marches.

Commissioner Carroll: I think that is a very important point. Later we did investigate a few offences that came out of it and did take action. However, it was a wonderful, compliant group of people at the end of the day, having their say. All in all, it was incredibly well managed between us and the protesters under what were very difficult circumstances.

Mr O'ROURKE: Firstly, I have to congratulate the Queensland Police Service and Dr Young on the absolutely wonderful job you have been doing protecting Queenslanders. My questions will be directed to Dr Young. Can you advise what authority you, as the Chief Health Officer, have to give groups or individuals exemptions from health directives, and how many exemptions you have actually granted?

Dr Young: I have that authority. It is written into all of those directions that I have the authority under the act to make those decisions. That is for a number of reasons. We have been gradually tightening and tightening the reasons an exemption can be given, but there is always that catch-all in extreme, extenuating circumstances. At the moment, I look at every single exemption that is applied for, where someone thinks that there might be a reason to give it. If the staff believe there is absolutely no way that the exemption could be given, then they say no, but if they think there could be, then they come to me for me to look at it.

There are two parts to an exemption. The first part is to exempt people to come physically into Queensland. The second part is—if they have asked, and some people do—to exempt people from hotel quarantine. They are the two parts and they are two separate decisions.

If someone asked to be exempt from hotel quarantine, I will go through that. There have been very, very few occasions where I have exempted people and have become tighter as we have gone through. Initially, when you think there were tens of thousands of cases, it made more sense that the chances were much lower that someone would bring the infection into Queensland. You heard the figure earlier that now across the world there are more than 22 million people with the virus, and every single day there are more and more people who are getting the virus and therefore potentially, if they come into Australia, bringing it into Australia. The ability to exempt people has become less and less possible because of the risks of people having the infection. There are very few now that are able to be exempted from hotel quarantine. Even those exempted from hotel quarantine will usually go into home quarantine or some other form of quarantine.

There are some people, of course, who have to be exempted. Freight is the one that is top of mind. We need to be able to move goods around Australia. People need our goods from Queensland. We are a net exporter of food, so we need to be able to move food out of Queensland and therefore those trucks need to come back in. There is a freight process. The freight industry has been absolutely magnificent in terms of working with us to minimise the risk. Nationally they have taken on board the process that we put in place in Queensland. We ask the freight drivers to get themselves tested every seven days, no matter whether they have symptoms or not. It becomes part of their routine. They find a convenient place to get tested and they can get tested. We do not require them, unless they are unwell, to go into quarantine or isolation while they wait for that result. That gives us some assurance about their risk to the general community. We need freight to continue.

There are a few others. We have some general exemption classes because we need those people for the functioning of Queensland. Seasonal fruit and vegetable pickers are absolutely critical. We can see that they have a very, very good process. We had that fruit picker who came in and was positive and it worked. The system worked around that. We have the fruit and vegetable pickers come in and quarantine where they are working. They work while they are in quarantine for the first 14 days. That is critical because fruit and vegetable picking seasons across the country move geographically—with such a big country—so they need to move to where that work is. We have that group.

Then we have mining and resources sector people. Again, we need them for the functioning of Queensland. They have had very good systems in place from the start, so that is well managed. Another group is construction workers. We need construction to continue as it is an important part of Queensland's economy. In my mind, those three groups are essential to Queensland's functioning, but also, if we were to have a case, they are contained. We might have a case in a construction worker on a construction site. It would mean closing down that site, but it would not be out in the general community. They have good systems in place.

It is the same with mining. It is important for them. I can tell you they are managing the workers brilliantly because they do not want an outbreak in their mining or resources sites because they know that would be the response: we have to close it down. The same with seasonal fruit pickers. We do not want them going out into the community, but if there were to be a case, we would close down the farm where they are working, and the farm knows that. We can restrict those three groups.

The areas we cannot restrict where we have been very firm about not giving exemptions are, firstly, healthcare workers. I cannot have healthcare workers coming into Queensland, going into a healthcare site and potentially having to close down the whole of the Royal Brisbane and Women's Hospital or the PA Hospital or the Cairns Base Hospital. The risk is far too high, so I require all of them to go into two weeks quarantine before they go to work. You might remember we had that one

worker in the Cairns pathology laboratory and we ended up with over 250 people having to go into quarantine, and we had to bring in staff from the rest of the state to run that laboratory. That was just a laboratory, let alone a whole hospital. It was only the laboratory that was at risk.

I make risk assessments based on what I think the risk is and what the other side of the equation is—where we need to keep things going but the risk is much less or where we just cannot manage the risk. It is the same with the police. The police are absolutely fantastic. There are a lot of police officers who live in Queensland and work in New South Wales and vice versa. That risk in my mind is too high because police are out in the general community, and some members of our general community are not always pleasant to police, if I can put it that way. The police are at higher risk of contracting the infection in those situations and then they come back into Queensland and because they are in the community in Queensland they could spread it. Police immediately put in place a process to manage that.

We had a process for police and we had a process for healthcare workers. The other one is teachers because teachers have such a lot of contact with people in the community and the school. They have a large number of people that they have to deal with. Again, they have had to sort out their arrangements there. We look at every single group and make risk assessments about what the risk is: if they were to bring the infection into Queensland, how would that be managed?

Yes, I do have that ability under the Public Health Act to then issue exemptions for different classes or for individuals who apply. I am sure some people think I am too lenient here, but I am the Chief Health Officer and my background is health, so I do exempt people who need healthcare services that can only be delivered in Queensland. We know that there are a lot of people in northern New South Wales who access their healthcare services here in Queensland. The police have to manage that at the border and they do that very, very well. I know it is a large number, but that is because a major city and communities are just so close to the border. You can imagine that people travel from northern New South Wales to Queensland for healthcare rather than travelling to Sydney or even to Newcastle.

We do have a process there. I need assurance from the place they are getting treatment from in Queensland that they will treat the person as if they had COVID-19. I do not know whether they do or do not, but they are coming from a high-risk area so they need to treat them as if they do. They are healthcare services and they know how to treat people and to manage it so that no-one else in that healthcare facility is at risk if they were to have COVID-19.

Mr O'ROURKE: Is there a right to an external review of your decision?

Dr Young: Yes, there always is. People can always go to judicial review for any decision made by a public servant. That right exists, of course. We do try to work with people to find out why it is that they want a review and understand that because sometimes they do not give all of the information the first time and then you find out that it is because they have a relative who is dying who they want to see or they might be escaping domestic violence. There are often other things in place. We then try to work with them to find out why they are wanting that review of the decision. Yes, as with any decision made by a public servant, of course there is a review process.

Mr BERKMAN: I want to echo the other committee members in saying thanks and congratulations for the amazing health outcomes we have seen. I want to start, Dr Young, with a question about borders and it is quite a specific circumstance that has been brought to me more than once by locals—that is, the circumstance where people who live in Queensland outside of the border bubble postcodes but who have properties that are within the border bubble in New South Wales. We are talking about rural properties in each of the instances I am referring to. They are prevented from getting there to undertake maintenance works even though it does not involve any contact with anyone in the community. It is simply a trip to the property and back. I appreciate what you said in your introduction about consistently finetuning and needing to strike a balance. Is there any consideration of circumstances like that where, for example, someone living within the Queensland bubble could make that journey to and from without any real problem but someone living slightly further away is restricted?

Dr Young: I have given many, many exemptions for that exact reason. I think the problem—and I have asked our communications team to fix it—is that people think that the only way to get an exemption is through the border pass. They need to go through a different process. If you live outside the border zone, whether it is in New South Wales or in Queensland, it does not mean the answer is automatically no. It means that you have to go through a different process and seek an exemption. You can go online. Since June we have had more than 14,000 exemption requests. People are putting them in and they get turned around reasonably quickly. That is a very large number. That specific circumstance I have given quite a number of exemptions for. There is no risk. The exemption is that

they can travel to their property but only to their property—do whatever they need to do there, stay for the time that they need to stay there, and come back. The idea is not that they go out into the general community and into the town. They need to go to their property. There is no issue with that.

Mr BERKMAN: I am sure that will be very welcome news to the couple I met with just this morning.

Dr Young: Please apologise. I understand that the website is difficult, and it is not always easy for people to navigate their way through it. We are trying to get some extra information out.

Mr BERKMAN: It is a process of refinement, as you say. I did want to ask some questions of QPS. The assistant commissioner has described the process of review of PINs that are issued, and I understand that has changed over time. I am curious to know whether any steps have been taken to ensure that any enforcement action, including the issue of PINs, is regularly and publicly reported, as well as any information that can be publicly reported about the process of review. Are any steps being taken in that respect?

Deputy Commissioner Gollschewski: We have done some analysis of all the PINs that we have issued. I think we are up to 2,300 or something. As the commissioner has indicated, the internal review started very early. We did see confusion amongst some of our officers at times around what the directions meant. It is a new system. As the commissioner said, we have never done this before, so we had to do that internally and be proactive around looking at those that were issued and where there were issues and withdrawing them when that had to happen. That has been happening all the way through.

We are also very curious about what was happening and where the people were who were most likely to commit offences that resulted in an enforcement action. We have done an analysis of that—and we are prepared to make this public; we have only just recently got the results on this, but I am happy to talk about it now. Our analysis of that shows that demographically it reflects population areas, so we are not seeing any particular area get any more PINs than anywhere else. Obviously the most are in Brisbane and the south-east corner. That is where we are seeing most of them. What we are seeing is that it is age specific. More than 50 per cent, around 52 per cent, are people aged between 19 and 29. If you go to 39, it takes it up to over 70 per cent. Over 70 per cent—exact figures are around 72 per cent—are male. This is really consistent with what we see in our normal offending population. Young males are most likely to breach at a level that requires an enforcement action.

We are not able to get any more specific demographic type indicators because they are not collected for on-the-spot fines. For us to do anything around that, it would take a lot more work. That is what it is telling us at the moment. What we are pleased about to some degree is that we are seeing it replicate what our normal offending population looks like, so we are not seeing any particular spike anywhere. Also, we have mapped that against our complaints. Our complaints for COVID related issues are much lower than our normal police complaints. The commissioner's commitment to that 'compassion and communication before compliance' approach we think is replicated through that.

Commissioner Carroll: There is no issue not to make all of that publicly available in terms of the process and what we have found. For us it has been a very educative process in itself. That is fine. Anything we get we can make publicly available.

Mr BERKMAN: Is it possible to do that?

Commissioner Carroll: Yes.

Assistant Commissioner Chelepy: In our press releases we regularly release the number of PINs we have issued and the number of PINs we have withdrawn. We have spoken on the public record on a number of occasions about our review process and also the process for the public should they have concerns about a PIN.

Mr BERKMAN: Yes. We have kept an eye on those. It does appear to be a fairly regular process. I am eager to see that that captures the full suite of work in the enforcement action that is taken. I also wanted to follow on from the questions that the member for Nicklin asked before—and we discussed this in the previous hearing, Dr Young. It is clearly possible for protest action to take place in a way that is safe and in a way that minimises, as far as possible, the risk of transmission. Commissioner, you mentioned before the way the briefing, the operational orders, prior to the Black Lives Matter protest involved consideration of wearing masks and maintaining social distance. I expect you are probably aware also of the protests that have been ongoing around Kangaroo Point.

Commissioner Carroll: Yes.

Mr BERKMAN: I expect you are aware, but I am not sure, of practices—I have seen footage of this, and I am sure it could be made available if you need to see it—where police officers have forcibly, whether by direction or with physical force, pushed protesters into a space where they are confined

and where they cannot practically maintain that physical distance. Obviously what we know is that that will increase the risk of transmission. Are you aware of that having happened? Have any steps been taken to prevent it happening again?

Commissioner Carroll: I would have to take that on notice because I do not know the exact details of that event. I do have an overall view of how we police those events, but certainly I am not aware of the specific incident you are talking about. I can take that on notice and bring the information back to the committee.

Mr BERKMAN: If it is any use, I am sure I could arrange to get phone footage or video footage—

CHAIR: Keep it in the context of operational police doing their job in a very difficult space. I just want to bring it back to what we are here for today.

Mr BERKMAN: Certainly. I am talking very specifically about operational policing and how that interacts with the ability of citizens to observe health directions and what the implications of that are.

Commissioner Carroll: We are always mindful of social distancing. I have to say that a lot of the protests have been exceptional. When you look at the footage and what they do, they actually have maintained their social distancing in undertaking their protest activities. I will look at that specific incident and I will get back to the committee.

Mr BERKMAN: I will make sure that I arrange to get that footage to you through the secretariat.

CHAIR: We see footage of police. Every day they get up and put uniforms on and go and do this amazing work at the hard borders. I have no doubt that there would be times—and we have seen this in the media—when police are being abused for doing their job, for keeping us safe. I just want to talk about that human element. What processes and support are in place for police? The burden of responsibility must be enormous.

Commissioner Carroll: It is interesting you should say that, because we actually have had a lot of abuse in the last couple of days over entry into Queensland for medical reasons and implementing the different arrangement. It does happen, but it goes to the point that from the very outset—this has been really quite a purposeful and strategic decision—we have talked about the educative process, because it has been extraordinarily dynamic. Even in the most difficult situation where there is such angst we tell our people and educate our people to settle them down and then explain why, and that extra moment actually changes the dynamic dramatically. Yes, we certainly have had a bit of abuse in recent days, but it is comparable to what normally happens. We are accepting of that in very difficult circumstances. I have to say that overwhelmingly Queenslanders just have been extraordinary in this response and how they have treated us and how we have got the message through to them. It has been exceptional—quite exceptional.

CHAIR: It is truly admirable work, and thank you very much.

Mr McARDLE: Thank you for being here today, all of you. Dr Young, you mentioned the issue of quarantine earlier. Can you advise how many people have been able to quarantine at home and not at a hotel under the act since the pandemic was declared in Queensland?

Dr Young: I will have to take that question on notice. I apologise, I do not have that figure with me.

Mr McARDLE: Thank you. The next question I have relates to the COVID-19 hotline. This is a pivotal communication tool between Queensland Health and the public and, indeed, yourself. Can you confirm that those who man that hotline are Queensland Health employees, first of all?

Dr Young: I am not sure which one you are referring to. There is 13HEALTH, which is our main communication strategy. That is open for absolutely anyone to ring anywhere in the state or, indeed, interstate if they have a reason to. Then we have our health directions line that people can ring.

Mr McARDLE: Let's look at the information network that is contactable by telephone through Queensland Health. First of all, are the people who answer the calls Queensland Health employees?

Dr Young: No, not necessarily. They work with Smart Service Queensland—

Mr McARDLE: I am sorry, you are very softly spoken, Doctor. Can you raise your voice a bit?

Dr Young: The 13HEALTH hotline is manned by Queensland Health staff with the support of Smart Service Queensland so they can flex up and down. There are nurses who are employed to take calls. There are also other people who do some of the screening of those calls. There are a whole range of different teams. That 13HEALTH line is also our Quitline and a number of other services.

CHAIR: I think what might help, Deputy Chair, is when Dr Young is speaking you are best muted, because we are getting a lot of feedback.

Mr McARDLE: Let's just go over this again, Doctor. There are a number of methods to contact Queensland Health by telephone. Some of those phone lines are manned by Queensland Health employees and some are not; is that correct?

Dr Young: That is correct. Smart Service Queensland—

Mr McARDLE: The next question is this: the Queensland Health employees, are they registered nurses, enrolled nurses or AINs? Do you have any idea?

Dr Young: Yes, I do. There are a whole range of different people depending on what the call is about. There are registered nurses there for clinical calls, but there are other people for other calls.

Mr McARDLE: Those who are not Queensland Health employees, what qualifications do they have?

Dr Young: They are employed by Smart Service Queensland, so by that department.

Mr McARDLE: I accept that, but they are taking calls from the public in relation to COVID-19. What qualifications do they have to assist a person querying COVID-19, which is a medical condition?

Dr Young: They may take the call if there are more calls than the staff in 13HEALTH can manage, and then they will distribute those calls to the 13HEALTH people, depending on what the call is about. A lot of the work done by 13HEALTH, of course, is scripts. It depends why people are ringing. A lot of the questions are not clinical questions.

CHAIR: Perhaps to put it in context, how many calls—

Mr McARDLE: Chair, thank you very kindly. It is my line of questioning, if you do not mind. The issue I then have is if there is no training for these people and they are reading from a script, if I go to the Queensland Ambulance Service and I also go through the call centre, they are manned by paramedics, people who are qualified. My concern is that these people are not qualified to—

CHAIR: Deputy Chair, you just made a statement that Queensland Ambulance Service call centre staff are paramedics. They are emergency medical dispatchers, not paramedics. I am not sure what rabbit hole you are going down.

Mr McARDLE: They are trained. My question is: these people are not trained—

Dr Young: I am sorry to have to interject. They are extremely well trained at taking calls and working out who is the best person to answer that call. They give us enormous support because the calls to 13HEALTH—I am just trying to find the numbers here—go up and down, so we need to be able to flex that workforce up and down. By being able to do that, we are able to answer all of the calls that we receive in a timely way. A lot of the calls are quite straightforward to answer, but people want those answers so it is important that they are answered quickly.

Mr McARDLE: Dr Young, the next question I have is this: there is media commentary that your advice to the Premier may have been to keep the borders closed for New South Wales, Victoria and the ACT until Christmas. Could you dispel that rumour, or is it essentially correct?

Dr Young: No. The Premier actually went out and did media and reported what has been said, not only by the Premier of Victoria but our Prime Minister, that there may be a requirement to keep the restrictions in place in Victoria until Christmas or, indeed, after. At the moment there is actually a day-by-day examination of what is happening. I meet with my colleagues around the country every day. We do not meet on weekends anymore unless there is a new issue, but Monday to Friday, to find out what is happening in those states and territories where their cases are and what impact that may have on Queensland. After those meetings we make a decision about whether we need to change our response in Queensland as a result. That is a daily decision-making process.

Mr McARDLE: Dr Young, have you recently given advice to the Premier that we should consider keeping our borders closed until Christmas to New South Wales, Victoria and the ACT?

Dr Young: No, I have not given that specific advice. I have said to the Premier, as I say most days—because I do meet her most days—that we need to take this day by day. I know that people across the state want surety. I would love to have surety, because I do not know how long I am going to have to keep staff doing what they are doing across the state and how long I am going to have to ask my colleagues in police to continue all of the work they are doing. It would be fantastic if we could all have some surety about what is happening. That is just not possible. It is actually a day-by-day decision, although I know how frustrating that must be for government agencies, for businesses out there trying to plan, and for the general community. It is extraordinarily difficult.

Mr McARDLE: I will put this question to you then: you could not rule out, given the current situation, that the borders to New South Wales, Victoria and the ACT could be closed until Christmas.

Dr Young: I cannot rule out anything, unfortunately.

Mr McARDLE: Thank you. I want to talk to you if I can, Dr Young, about the Australian Health Protection Principal Committee, of which you are a member. We have had evidence today from the college of physicians and also earlier evidence in relation to PPE in the early stages. There seemed to be a gap point as to what the modelling indicated could be the outcome of the first wave of coronavirus. There have been a series of pandemics or other disease related issues going back to 1997 building up through bird flu, avian flu, SARS and H1N1, and they have all been close enough to our border to be concerning. It was only a matter of time before something crossed the border, I suspect, given international travel and given that we are a very small planet compared to 60, 70 or 100-odd years ago. I am just curious to understand at that point in time, given the history of pandemics over recent times—the last 20 or 30 years—why we were not properly prepared with PPE and ventilators, because there certainly seems to have been a scramble to try and put that into production.

Dr Young: We did have a stockpile in Queensland. It was actually the biggest anywhere in the country other than the Commonwealth stockpile. That stockpile was put in place in Queensland for the public health system and for other government agencies if they needed it at that time. There was always the intent that the Commonwealth stockpile would be utilised for the primary healthcare sector, and indeed it was. GPs and pharmacists could access the Commonwealth's stockpile through the primary healthcare networks, and they did. A lot of GPs made a decision at that time—which I think was very sensible—that they would not be testing patients because that is when you actually needed the PPE. Instead, they would assess patients using telehealth, and the Commonwealth government put out Medicare item numbers very, very quickly to enable GPs to do that. So they would organise telehealth appointments, assess their patients and refer patients to the nearest testing centre. Then I provided, out of the state stockpile, PPE to those testing centres so they could safely test patients.

We were very careful because we did not know how long it would take to replace those stockpiles. To be absolutely honest, I am not sure that anyone in the world expected to have an outbreak of a disease in a city where the vast, vast majority of the world's masks were made. They were not sending those masks out of Wuhan because they needed them there. That is where the vast majority of the world's surgical masks came from. That is an amazing coincidence that we had not prepared for. We had prepared a stockpile. It was quite a significant one, and it got us through until we were able to source stock. Now in Queensland we have Queensland companies making surgical masks here in Brisbane that are TGA approved, which is excellent. I think that will be the big change out of this pandemic going forward. I do not think we are ever going to allow ourselves to go back to a philosophy of 'just in time' procurement, which was the philosophy I certainly learned about when I did my MBA. That was the way that society worked. In a global world, it was about minimising storage and ordering things just in time.

We never went that far in Queensland, mainly because of our response to disasters. We have never been quite sure that we would be able to get things during our cyclone season, so we have always had stockpiles across the state in Health—and I am sure in other government agencies as well—because we have not been sure that we could move stock during our summer season. Indeed, every year we see some part of the state cut off for weeks at a time. Queensland has always had a philosophy of having a stockpile, both for personal protective equipment and also for medications, because again we know there have been problems accessing those over the years, so we have had a stockpile. Was the stockpile big enough? I am sure it will be bigger going forward, but it got us through. At no stage was any health professional ever asked to look after a patient without the appropriate PPE.

Mr McARDLE: Thank you for that. We were given figures that were also spoken about on the last occasion we met of between 10,000 to 30,000 Queenslanders were expected to die within the first wave, and we would be in the middle of that right now, if I recall correctly. Can you release the modelling that established that figure?

Dr Young: Yes. That was based on international modelling—

Mr McARDLE: No, the actual documentation. I do not know if it has been released yet.

Dr Young: Yes, I think the Commonwealth has released it. It is up on the website for the Doherty Institute, so it is publicly available. That has all been released right at the start and subsequently they have updated that as new modelling. The initial modelling that I based those first figures on was that broad international modelling and then we started getting information in Australia. Because our health system is different to a lot of the rest of the world where these cases first started,

we saw some different numbers in terms of people requiring admission and people requiring ICU. We are putting a lot more people into ICU who get this disease in Australia than overseas because we have the capacity. Here in Queensland, for instance, our numbers that have gone into ICU have been higher. To date, we have had 16 people go into ICU and 15 of those have survived, which is a very good statistic. Overseas they have seen that only around half of the people who go into ICU survive, and that is not a commentary about their ICU; that is a commentary about the numbers of patients they have been able to admit into their ICU. The initial modelling was based on international work and then subsequently the modelling was based on real data here in Australia, and it is all publicly available if you go on to the Doherty website.

Mr McARDLE: Thank you.

Mr HUNT: Dr Young, I take you back to the start of this hearing where you mentioned our four ways out of this. We have eliminated one and two; we are down to vaccine or treatment. In light of that and in light of the fact that we may never get to that point, as optimistic as we may be, and in light of the fact that Queensland borders aside—let us forget about the borders for the moment—we are probably in the best position we could be in or it is never going to get any better than this. Can Queenslanders look forward to the further easing of restrictions throughout Queensland as we progress? If we are talking about at least 12 months to a vaccine, can we look forward to perhaps an updated road map or further easing of restrictions recommended by you?

Dr Young: Of course. It really will depend on what happens in Victoria and New South Wales. I think we have very tight international borders now, and that has been managed around the country very effectively. It is difficult to manage the domestic border because we need people to cross the border. We cannot isolate ourselves in Queensland from the rest of the country. We just cannot do that. We need to move freight across the border. There are certain workforces we need to move across the border. While there are cases actively occurring in communities in other parts of the country, we will not be able to remove restrictions. That will be difficult to do because we have to be on edge almost, expecting that there could be a case in our community. If we were to miss that first case, then we could have subsequent cases and be in the situation that Sydney is today. Most of their cases came from one gentleman who had come up from Melbourne who did not think he was sick and spread it and they have ended up with multiple outbreaks as a result. You would have seen that in Victoria they believe that most of their cases there—their thousands and thousands of cases—go back to one of their quarantine hotels. We can all see that just one case missed early on in the chain of transmission can lead to a large number of cases, which is why we do need to maintain those restrictions, as onerous as they are—and I know how onerous they are—to protect ourselves from having broader spread.

Mr HUNT: As a quick supplementary to that, I said specifically to take the borders out of it. Within Queensland, if we can keep our infection rate as low as we have across the last however many days it has been of no infections—if we can keep that going, regardless of what is happening in Victoria—can we expect recommendations by you to whoever the Premier is to ease restrictions in the near future?

Dr Young: It is unlikely while our borders still need to be open to certain workers and certain situations. We can close our international borders, and we have a lot of protections there. At sea Maritime Safety Queensland is doing a fantastic job to manage those maritime risks into Queensland and then at the international border police working with Border Force and ADF, when they are involved, are doing an amazing job protecting our international air border, but it is a totally different process for domestic borders. It is very, very difficult to see how we could fully open up Queensland internally while we still have that risk of people from both Victoria and New South Wales coming into Queensland.

Mr HUNT: Thank you.

CHAIR: We are just about at time, but I want to clarify one point. Before I do that, I ask that any questions taken on notice be back by Wednesday, 26 August. I want to clarify the deputy chair's line of questioning earlier around the call service for 13HEALTH. There was commentary around the Queensland Ambulance Service. I want to give my thanks to our emergency medical dispatchers—my colleagues—in the Queensland Ambulance Service. They would be screening calls for people who potentially could be at risk of COVID and passing that information on, but just to clarify that those paramedics and the registered paramedics on the road are two different groups. I just wanted to clarify that point.

I thank you, Dr Jeannette Young, for your time here today and for continuing to keep Queenslanders safe in every decision you make and the thousands of decisions you have to make. It is really admirable work. Thanks also to Commissioner Katarina Carroll and your colleagues the

deputy commissioner and the assistant commissioner for being here today and for the outstanding work the Queensland Police Service do—every single staff member. You must be incredibly proud of them for helping to keep Queensland safe. Thank you so much for your time today. We will adjourn for a short break and come back at 12.40 pm.

Proceedings suspended from 12.22 pm to 12.40 pm.

BURGESS, Ms Mary, Public Advocate (via videoconference)

CORKHILL, Ms Heather, Senior Policy Officer, Queensland Human Rights Commission

COSTELLO, Mr Sean, Principal Lawyer, Queensland Human Rights Commission

LEONG, Ms Rebekah, Principal Lawyer, Queensland Human Rights Commission

McDOUGALL, Mr Scott, Queensland Human Rights Commissioner, Queensland Human Rights Commission

CHAIR: I welcome our next panel of witnesses. I invite you to make an opening statement, Ms Burgess, and then we will move to the Human Rights Commission.

Ms Burgess: Thank you very much. I would like to thank the committee for inviting me to give evidence today and I would like to acknowledge the traditional custodians of the lands on which we are meeting and their elders past, present and emerging. I would also like to acknowledge people with disability and older people who experience discrimination and exclusion every day. For the benefit of those who are not familiar with my role, the Public Advocate is an independent statutory position established under the Guardianship and Administration Act and my key role is to undertake systemic advocacy to protect the rights and interests of people with impaired decision-making capacity.

The COVID pandemic has been a critical time for government and the Australian community. In my view the Queensland government's health response to the pandemic to date has been an unquestionable success. I particularly want to commend Queensland Health for its work convening and supporting a number of interagency working groups that have been meeting regularly since the beginning of the pandemic. I am currently a member of two of those COVID-19 working groups for aged care and for disability support. These groups include stakeholders from government agencies, service providers, community service and advocacy organisations and they have proved to be an invaluable resource throughout the pandemic, ensuring cross-agency cooperation on key issues. They have supported information sharing, they have helped to identify emerging issues and gaps in information and provide guidance to the community and service providers about the virus and also the interpretation of the public health directives.

I also want to acknowledge the efforts by Queensland Health staff and other agencies and in particular the NDIA in progressing the discharge of long-stay patients with disability who were medically ready for discharge from hospital but had spent a long time in hospital waiting for that community transition. In the four months from the end of March to the end of July there were almost 400 people who were transitioned to community living and, while this is a very positive development and demonstrates what can be achieved when we are all at one in terms of our objectives, it is important that the state government continues to monitor this group of very vulnerable people to ensure they have the necessary supports to maintain their health while living in the community. The need to protect the most vulnerable in our community is essential during this crisis, but it is also important that we balance these responses with the need to protect people's human rights.

I am concerned that some of the legislative amendments that have been introduced during the pandemic will have negative consequences for people with disability that may be felt far into the future. Amendments to the Disability Services Act made in response to the pandemic now allow for people with disability in care settings to be locked in their own homes if a service provider considers that it is 'necessary' to comply with a public health directive. There have been amendments to the Forensic Disability Act that provide for Forensic Disability Service clients to cease access to some services and all outings into the community if they could pose a risk to the health, safety or welfare of that person or others. Inexplicably, from my point of view, these amendments were introduced when the government was easing restrictions under the public health directive, yet they now are in place and able to be used lawfully against a person with disability until 31 December this year and possibly beyond that if they are extended.

The key concerns I have with the amendments and the way they were introduced are that there was no consultation with people with disability, with disability service providers or advocates about the amendments. There was no demonstrated need for these amendments that was provided. In my engagement with government, no-one provided me with a single example of a person with disability acting in a way that was in breach of the public health directive that would justify the passing of a law

to permit the locking of gates, doors and windows in the homes of people with disability to limit their freedom of movement. There is also no requirement for reporting, monitoring or oversight of the use of those powers, so we will have no idea how often they have been used, why they have been used during the pandemic or whether they were used lawfully or otherwise.

The legislation also bypassed many of the usual processes for scrutiny of legislation during the parliamentary process. The authorisation of actions that would otherwise constitute criminal or tortious acts against a group of vulnerable Queenslanders is a significant infringement of their fundamental human rights. I am particularly concerned that the amendments will contribute to the stigmatisation of people with disability by feeding into negative stereotypes of people with disability as spreaders of disease, as unreliable and as unable to follow direction.

I am also concerned about the negative impacts of social isolation for people with disability who often experience fragile mental health. The issues that have been raised by the passing of the COVID related amendments raise genuine questions about what it means for Queensland to be a human rights jurisdiction. How should we be approaching the development and passing of legislation now that we have a Human Rights Act when the legislation touches on these very critical issues? Should we be considering different processes to ensure that the laws that we are introducing as we go forward embody the Human Rights Act principles?

In closing, I make the point that as we struggle to make the difficult decisions that will continue to need to be made as the pandemic progresses to keep the community safe, it is important that we also remain vigilant in protecting the human rights of all Queenslanders.

CHAIR: Thank you very much, Ms Burgess; a good segue to the Human Rights Commission.

Mr McDougall: Thank you, Chair. My opening comments are reflective of the Public Advocate's comments as well. First, I acknowledge the traditional custodians of the land on which we meet today and pay my respects to their elders past, present and emerging. The purpose of the Human Rights Act is to respect, protect and promote human rights in Queensland. The establishment of this committee was a much welcomed and important development to ensure that the government considers the impacts of its decisions and actions on the human rights of people in Queensland, even amidst a pandemic. I thank you all for your diligence.

We commend the government on making tough decisions to protect lives. Clearly, the Queensland government has taken its obligation to take positive steps to protect the right to life very seriously. In this regard, we acknowledge the Chief Health Officer's work in making directions that prioritised the preservation of human life. However, we urge the committee to be aware that this public health response has come at the cost of restricting other human rights, especially the human rights of certain at-risk communities such as people in aged and disability care and in closed environments, including youth detention centres.

The commission is monitoring restrictions placed on human rights by the government and hears from people who have been adversely affected. We urge the government to give careful consideration before limiting rights and to explore less restrictive options for protecting public health. The Human Rights Act provides a valuable framework to assist us to balance competing rights and interests. One positive that has come out of the last six months has been the flexibility and willingness of many public sector workers and departments to find solutions that preserve human rights yet protect the dignity of individuals whilst also minimising the spread of the virus.

Another positive outcome has been the demonstrated effectiveness of the commission's complaint-handling process, which you might be aware is a unique feature of Queensland's human rights framework. The complaints mechanism has led to several successful outcomes in cases where people have complained about the conditions of their mandatory hotel quarantine. While we find ourselves in extraordinary times, the foundations of our democratic parliamentary system should not be weakened. We have been concerned that, during the pandemic, some bills have been passed without committee consideration or with late amendments—for example, the changes to bail laws for young people being made through the Community Services Industry (Portable Long Service Leave) Act which was passed with amendment on 17 June 2020.

In closing, I wish to commend the public sector workers at the frontline of this crisis, particularly Queensland's health workers, police officers and teachers. The position Queensland now finds itself in is due in large part to their hard work and professionalism as well as the commitment of the broader community to make sacrifices for the common good. I am pleased to take any questions.

CHAIR: Thank you very much, commissioner. Perhaps this morning we should have put you before the Chief Health Officer whom we have just heard from for the last hour and a half. This is a delicate situation where we are protecting the public and, at the same time, have to give good consideration to human rights. In regards to complaints so far, I note that at the time of writing in early July the commission had received 1,199 inquiries and 30 complaints relating to COVID-19. Can you give an update on that and perhaps a breakdown of the common themes? Is it around hotel quarantine?

Ms Corkhill: I can answer that question. The commission has continued to receive complaints and inquiries. To date, we now are up to about 260 inquiries and around 30 formal complaints. Hotel quarantine remains a key issue. Other issues include education, issues in closed environments including prisons and youth detention, tenancy matters, child safety and also employment. We have noticed a new trend of employment matters arising through complaints and inquiries. There may need to be some stronger responses to protect the more vulnerable workers such as First Nations people, older workers, workers with a disability and pregnant women who are telling us that they feel targeted for redundancies and dismissals compared with other workers. That is sort of a new trend we have seen emerging.

CHAIR: You both raise similar issues in your submissions around when health directives are made those being accompanied by a statement of the purpose, need and date and other factors considered in making each public health direction—essentially publishing a written justification for the making of the health direction. Did you both want to comment on that?

Ms Burgess: We would welcome action to provide that kind of information to the public because, firstly, it explains to people why they are required to restrict their movement or their work. It helps people to understand why the decisions are being made and to get them on board with the actions that are being taken. Providing that kind of background information also assists in the interpretation of the directions, and that is fairly critical. During the pandemic we have picked up that, with all of the best intentions, it is very difficult to put out a direction that is unambiguous and that everyone will be able to pick up and run with. The more information explaining how and why it is being driven is going to assist in people complying, accepting and running with it.

Mr McDougall: The issue of communication in this pandemic has been really critical. Clearly, we in Queensland have had very strong leadership and, overall, very good, strong communication. The area of hotel quarantining is one area where there is scope for improvement in the quality of the information being given to people coming into quarantine. I saw the evidence this morning of the Police Commissioner who made it clear that the police are assuming a role in coordinating and leading hotel quarantine decision-making, but the information coming to us through our complaints is that that is not the message that people coming into quarantine are getting. They are getting the message that decisions—for example, about access to fresh air and breaks—are in the hands of either Queensland Health or the hotel itself and then sometimes in the hands of police.

Queensland Health and the Chief Health Officer have been incredibly available to us throughout this whole process. This is something about which we are in continuing discussions. There are lots of human rights issues engaged, as you can tell by the breadth of our submission, in a pandemic, but one of the key issues that is a bit of a live issue at the moment is this issue of hotel quarantining. To my mind, there is an unresolved issue that goes to the selection of the hotels. There is a real problem with hotels being used that just simply are not fit for purpose for holding families for 14 days. That is an issue that needs more attention. We are certainly continuing our discussions with the Chief Health Officer about improving that situation.

CHAIR: My next question was about the communication from the commission either to Queensland Health or Queensland police. By the sounds of it, that has been established and, hopefully, resolution can be found when obviously raising these issues. It sounds like you have good communication?

Mr McDougall: Yes, it has been very good. In years to come, Queensland's response to this pandemic will probably be a case study that people at Harvard learn, because the systems are in place and, on the whole, are working very well. There will always be gaps as there always are, but on the whole the systems that are in place in Queensland—and it may go back to our history of disaster management—are working well. The prospect of a second wave in Queensland, as we have obviously in Victoria, is something that we should be preparing for. We need to anticipate the human rights implications of a second wave and the at-risk groups. They are things that I think it would be good if this committee could turn its mind to as well.

Ms Burgess: The two committees that I am involved in are looking at those issues in terms of preparing quite specific plans around issues relating to aged care, disability, testing, time frames and allocating responsibilities. From my experience, all of those things that are currently arising in the inquiries into what has been happening interstate are being developed and specifically addressed now. It is very positive.

Mr BERKMAN: I very much appreciate everyone's time here today. I have expressed previously my concerns about some of the changes we have seen that have been introduced as amendments without any kind of community oversight, as you referred to in your opening statement. Specifically, I am aware of the example you gave, Commissioner, of the changes to bail laws for young people and also the introduction of penalties of imprisonment for failure to comply with health directions. These are both changes that were made without the opportunity, as I understand it, for direct consultation with the commission. Do you have any views on those changes and the human rights implications that you are inclined to share now?

Mr McDougall: The issue of youth justice is obviously a live issue in Queensland and has been for quite a long period of time. We did have concerns about the way that amendment was passed and the lack of consultation about it, as well as obviously the impact of the amendment itself on the number of children being remanded in custody, bearing in mind the relatively low capacity of youth detention centres. The capacity of Queensland's youth detention centres is about 270 and the number of children in detention is hovering at just over 200. It is quite clear that it does not take much for those numbers to increase. The bail laws are critical to influencing those numbers.

CHAIR: I do not mean to interrupt, Commissioner, but I just want to keep it in the context of the inquiry on COVID-19 and the health response.

Mr McDougall: Just limiting it purely to the process then, ideally we would have liked an opportunity to be consulted or to make submissions to this committee or the relevant committee.

Mr BERKMAN: I might respond to the point from the chair and note that the question—and the commissioner was not given an opportunity to respond to this—did go directly to the question of penalties of imprisonment for a failure to comply with health directions. That is clearly relevant to the question of the health response to COVID-19, so I would ask if the commissioner has anything to add on that.

Mr McDougall: That is obviously a severe response. As to the question of whether it is proportionate and what safeguards are in place, obviously, the penalty would have to be imposed by a judicial officer so that is a key safeguard. I think at the time it was described as a requirement to deter people who otherwise would not be deterred by fines. That is something that would have to be considered as part of that proportionality analysis. We are in the grips of a pandemic where there are real-life consequences for thousands of people if one individual does act recklessly so I think that would be factored into the proportionality analysis as well. Again, the process of passing that law though was not desirable.

Mr BERKMAN: I want to go to an issue that was raised by the Public Advocate in her opening comment and it was also touched on in the commission's submission around those changes to the Disability Services Act. I understand from your submission that, following the introduction of those changes that gave discretion to service providers to lock people with a disability inside premises, you were engaged in consultation after the fact around the development of a policy for implementation of that. I just want to open it up to any comments you have on that. I am sure you have done whatever work you could in development of the policy, but has that process appeased your concerns around the changes that were made specifically?

Ms Burgess: When we participated in the development of the policy, I felt as though the contribution that the Human Rights Commission, the Public Guardian and my office made certainly assisted to produce a better policy outcome. In fact, it led to an updating of another policy around gates, doors and windows that the department has. What I think is shown by that is that consultation with agencies like ours does not necessarily obstruct; it actually results in a better, more nuanced outcome with better standards and all of the appropriate considerations being weighed up.

Too often there is a risk that agencies like mine and those which are advocating for human rights are seen as an obstruction, a delay, a slowing down of the processes, but that is exactly what we need in these circumstances where we are having to make very difficult but very rapid decisions. It is very important to have as many people in the room with different perspectives as possible to get the best outcomes. I need to say that, ultimately, the policy that resulted and the improvements in the policy did not necessarily address the concerns. We have no oversight of the way these decisions are being made. There is no reporting. We will never know how often they are used and whether they are all used properly because we have no process for tracking that at all.

Mr BERKMAN: Thanks very much.

Mr McARDLE: Thank you for being here today. My question is to the Human Rights Commissioner. There is a submission by COTA, which are appearing before us next. They refer to a document entitled *Queensland ethical framework to guide clinical decision making in the COVID-19 pandemic*. Their submission states—

This document provides an ethics based framework to assist in making clinical decisions about whether to withdraw or withhold life-sustaining measures from a patient at a time when those medical resources must be rationed due an overwhelming demand for intensive clinical support generated by a pandemic.

The submission then refers to the framework and what is termed in the framework as the 'life-cycle consideration'. They then quote the framework. They state—

Feedback from the community, identified this consideration as appropriate in complex occasions. Such that, when equivalent scores occur priority be given to children and adults <50, adults who have not yet 'lived a full life', 50-69 years and followed by those older.

They then say, and I am again quoting the framework from their submission—

While the life-cycle principle grants each individual equal opportunity to live through phases of life, there is relative priority to younger individuals.

My question relates to the United Nations High Commissioner for Human Rights which states that an older person has the same rights as any other age group and should be protected equally during the pandemic. This document that COTA referred to—and I repeat that I am simply referring to their submission—would appear to give significant power to doctors and clinical experts to decide in a crisis situation who should get treatment or not. The problem is that that is not an act of parliament and that the Human Rights Commission would not have been consulted I suspect on that document. There certainly are provisions in the Human Rights Act that do protect older people and also give the right to parliament to pass legislation that provides for exceptional circumstances to deal with situations. Can you comment on that document? I apologise for the length of time it took me to explain that.

Mr McDougall: That is okay. That is a very good question and a very important issue. Yes, we have had discussions with Queensland Health on that document and I will get Sean to talk about some of the detail of it in a moment. In terms of the potential for a situation to develop where there is a lack of ICU beds for people in Queensland who require them because of the COVID pandemic, at this point in time it does not look like that is going to arise, but it is still a potential that needs to be considered. There is a very real danger that the unconscious bias and indirect discrimination would lead to older people, people with a disability or people with cognitive impairment actually having their life ended earlier than they otherwise would if they had access to medical treatment. The decision-making around that obviously is critical and there has been an attempt by Queensland to develop an ethical framework to deal with it. I will pass over to Sean who has looked at this particular issue and he can talk about more of the detail.

Mr Costello: Thank you for the question. I think jurisdictions around the world have grappled with this issue in different ways. The Queensland government probably deserves credit for seeking to document some sort of framework about how these decisions are going to be made because that is something that other jurisdictions have not had. That transparency for the community is obviously important.

As the commissioner said, we have provided some feedback on that framework as it has been released. I think it is fair to say our concerns probably echo those of COTA that the deputy chair referred to—around particularly unconscious bias and assessing people's access to health care based on things like a frailty index. We continue to talk with Queensland Health about those and are hopeful that more considerations about unconscious bias, particularly for older people and people with a disability, can be factored into the framework.

To pick up the deputy chair's question around human rights obligations and who has obligations in particular situations, the other piece of feedback we have given on the framework is just to reflect that, most likely, the people who would be making the decisions in the public health system under this framework will be public entities under the Human Rights Act, and they have the obligation to act compatibly with human rights and make decisions giving proper consideration to human rights. That is something we have also considered should be spelt out clearly in the framework so that they appreciate what those considerations are going to be when they are put in those very difficult situations.

CHAIR: We are just about out of time. It is interesting to look at Italy. They were overwhelmed and there were literally decisions being made on who could be ventilated and who could not.

Mr McARDLE: Chair, I accept the comment you are making. I suppose my comment relates more to the power to either end a life or sustain a life and if that is not being run through an appropriate body like the Human Rights Commission as they would potentially do through an act of parliament. I just get concerned at the gravitas of the situation and if there is communication with the Human Rights Commission. It is not sufficient in my opinion to ensure the rights of the individual are upheld going forward without a proper and rigorous assessment.

CHAIR: I do not know whether the commission or the Public Advocate would like to add anything else, but any additional commentary will have to be sent to us because of our tight time schedule. We have COTA standing by now and we are eating into their time. If the commission or the Public Advocate wants to provide any additional information, we would welcome that. I apologise for the tight time frame but you have raised some very good points today and in your submissions and we thank you very much for your time.

STALKER, Mr John, Policy Coordinator, COTA Queensland (via videoconference)

CHAIR: Hello, Mr Stalker, it is good to see you again. It has been a little while. I do believe the last time you were in front of us was the Earle Haven inquiry. I do not know if there was a time before that. We welcome COTA and the submission you have made today to the inquiry into the Queensland government's COVID-19 health response. Would you like to make an opening statement?

Mr Stalker: Yes, I would. Firstly, I would like to thank the committee for allowing COTA's appearance today. On behalf of older Queenslanders, COTA Queensland wishes to thank the Queensland government for a well-managed and ongoing health response to COVID-19. We would also like to express our deepest gratitude to all those in the health, emergency and other sectors who continue to work tirelessly to safeguard their fellow Queenslanders from COVID-19.

COTA Queensland has raised a number of issues in its submission. A central issue relates to protecting the human rights of older Queenslanders. COTA was a strong supporter of the introduction of the Human Rights Act in Queensland as it would help to ensure that older Queenslanders could live in a safer and more equitable community.

When stories began to emerge from Europe about the need to ration access to medical treatment due to overwhelming demand, COTA was asked questions on a number of occasions as to whether health rationing would occur in Queensland. We advised, 'No, it could not. In Queensland we have the protections contained in the Human Rights Act that relate in particular to health services.' Not long after this, COTA along with other stakeholders were consulted on the Department of Health's document *Queensland ethical framework to guide clinical decision making in the COVID-19 pandemic*. The document's purpose is to provide an ethics based framework to assist in making clinical decisions about whether to withdraw or withhold life-sustaining measures from a patient. The need to have this framework to manage health service provision is understandable. However, what was not acceptable was the fact that the framework could single out and deny those seriously ill with the virus over 65 years of age from accessing life-sustaining treatment. These concerns deepened when it was realised that the safeguards contained within the Human Rights Act could be overridden by parliament in exceptional circumstances such as a threat to public safety, health or order. COTA Queensland accepts that situations may arise that necessitate the limitation of rights. However, at no time should such a limitation have an adverse health or safety impact on any individual or be based on the age of an individual.

COTA also believes strongly that pandemic planning and communication are essential in combatting a pandemic such as COVID-19. However, if community members are not aware of the actions they need to take and the reasons before a pandemic strikes, the response to the pandemic will not be as effective as it otherwise might have been. For example, in preparing for the bushfire season, community members are taught to prepare, act and survive. Why was this not the case for pandemics? Future reviews of the pandemic plans must involve more community level input and the implementation of the plan must be supported by a comprehensive public education campaign.

COTA Queensland also believes that governments need to more effectively balance the messaging used during this type of emergency event. Yes, some older Queenslanders were at greater risk of contracting COVID-19, but not all older Queenslanders were at equally high risk. Many Queenslanders under 65 were also in the high-risk category due to existing illnesses. However, the focus remained on older Queenslanders.

COTA Queensland acknowledges that governments have to take strong action to halt the spread of COVID-19. No reasonable person could argue otherwise. However, in implementing these strong measures, governments in their planning must also factor in the deeper social, health and mental consequences that flow from those actions. They must ensure that community and health service providers are adequately resourced to cope with increased demand for assistance.

CHAIR: We appreciate the issues raised. In fact, we just had the Human Rights Commission and the Public Advocate give evidence prior to you. They raised similar concerns. I will go to the deputy chair in reverse order because he was talking about your particular issue in the COTA submission. Deputy Chair, do you want to lead that following on from the last conversation?

Mr McARDLE: Yes, I will not be too long. Thank you for being here today. I raised with the Human Rights Commission a document you referred to in the content of your submission to the committee. They said there had been ongoing discussions between Queensland Health and the Human Rights Commission, and I suspect you have as well directly or indirectly. My concern is that this is not an act of parliament. As I understand the Human Rights Act, it does relate to acts of parliament. It also provides that in an act of parliament human rights can be restricted in certain circumstances. My concern comes back to the point of the Human Rights Commissioner that older

persons have the same rights as any other age group and they should be protected equally during the pandemic. I also take on board your comment that we are facing a situation that is unique—at least since 1918. Do you have any idea of how this matter should be addressed going forward in relation to that document and also the human rights obligations of governments across Australia?

Mr Stalker: Firstly, in terms of how it should be addressed going forward, we strongly believe that any reference to age in any guidelines that clinical practitioners will have to use to make such serious decisions should be removed. We do not believe that age should feature. We understand that people over 65 in certain circumstances can have greater frailty. Equally, as I have stated, people under 65 can be in a similar situation. We are not sure why they should be treated differently.

The other concern that I did not mention before does go back to pandemic planning. As far as we understand, the first real pandemic plan was developed around 1999. One of the issues it raised—there was a review undertaken in 2011 of the influenza outbreak that occurred in 2009. One of the things that that review mentioned was that Australia does not have enough trained intensive care health service staff. Equally, it does not have enough equipment to cope with the demands required within intensive care. One of the things that really intrigued us was if this was known in 2011, why were greater measures not taken to ensure that there were more trained health workers who could work in an intensive care environment who could be called in off standby. Equally, why has there not been a greater reserve of equipment that can be used in the intensive care environment that would help minimise having to make such difficult decisions?

From a Human Rights Act itself, as a layperson I must admit I do not fully understand the tests. For example, your committee would have to put a request from a department in terms of having an aspect of the Human Rights Act waived for a particular circumstance. Fundamentally, I do not believe that there is any justification that would arise that would justify threatening the lives of any Queenslander. The Human Rights Act is there to, amongst other things, protect life. We cannot have a system whereby, because the health system is unable to cope in certain circumstances, we allow people to have their lives basically threatened. People have the right in an advanced care directive to make the choice not to go beyond a certain stage in terms of their health treatment. However, if a person has not authorised that in their advanced care directive, we have an obligation to ensure they get the maximum support possible from our health service. I am not sure if I answered your question or went off on a tangent, so I apologise.

Mr McARDLE: You have answered the question brilliantly. Thank you very much.

Mr BERKMAN: We appreciate you joining us today. You have no doubt heard, as we all have, some pretty scathing submissions to the aged-care royal commission about the preparedness of the aged-care sector to deal with the pandemic. Could you share your views on what is coming out in the commission of inquiry and the implications for Queensland and our COVID-19 response?

Mr Stalker: I must admit I am not an expert in that area. We have left that side of things to COTA Australia. COTA Australia has now lodged its first submission to the aged-care royal commission in respect of lessons of the COVID-19 crisis, which is available on the COTA Australia website. They are in the process of preparing a more detailed submission that is due by 4 September. COTA Queensland has participated in collecting information from consumers and we are in the stage of finalising the compilation of that information. That will also be given to COTA Australia to use in the next submission. I must admit today I am not really in a situation to answer that question in detail. I am sorry.

Mr BERKMAN: That is fine and completely understandable. We can access those COTA Australia submissions for ourselves. Thank you.

CHAIR: It is interesting that you brought up the advanced healthcare directives. If you have been following our work, you would know we have just completed and tabled two significant reports, one of which was on aged care—picking up on the member for Maiwar's last question—palliative care and end-of-life care. We heard of the importance of having those advanced healthcare directives for everyone, whether they are older Australians or not so they are not dealing with these things in times of crisis. I think COTA will play a role because we did make recommendations around ensuring people do them early instead of in times of crisis. Of course, with COVID-19, our older Australians are the most vulnerable. They are the ones that were first asked to stay inside and only go out for essential shopping or use their families to do that. The older cohort do have comorbidities, whether it is heart disease or lung disease, as we heard from the Lung Foundation and Asthma Australia today. I do not know whether you want to talk to any of those points. It is imperative that we get advanced healthcare directives in place early.

Mr Stalker: Yes, and I had promised my wife I will get one in place when the new forms come out shortly. That is my current excuse, not that there is one. In our submission we made the comment about the focus on people over 65 and their greater degree of exposure to COVID-19 than other cohorts. While we accept that once you get to an advanced age such as mine you might have lower immunity levels et cetera or you might have other underlying illnesses, there are about 827,000 Queenslanders over 65 years of age. A large proportion of those are quite active, quite healthy and also play a very important role in their communities as volunteers. While we accept and appreciate the importance of social distancing and everything else, we were concerned that a lot of key activities in some communities were largely curtailed because the volunteer workforce in those communities were concerned about leaving home. They were trying to do the right thing but they also want to try to do the right thing by their families and other members of their community. In some areas and in some circumstances they could have still undertaken their community activities quite safely. There were also reports that we received of some older Queenslanders basically being abused by other Queenslanders because they were being held to blame because of the stringent measures introduced under social distancing. There were those concerns.

CHAIR: There were plenty rolling around in the media such as 'lock up the old people and open the borders'. There have been some outrageous remarks made during this pandemic. That is not what we want to do; we want to keep everyone safe, and that is the underpinning intent. We heard from Jeannette Young, the Chief Health Officer, this morning on that. Thank you very much for your time. We thank you and COTA for the work that you are doing. It is good to see you again. Thank you for your time today.

Mr Stalker: Thank you all and thank you for the work that your committee is doing. Thank you very much. Good afternoon.

CHAIR: I now welcome the next witnesses.

MACKAY, Professor Fabienne, Director and Chief Executive Officer, QIMR Berghofer Medical Research Institute (via videoconference)

YATES, Distinguished Professor Patsy AM, Executive Dean, Faculty of Health, Queensland University of Technology (via videoconference)

CHAIR: I now welcome representatives from QIMR Berghofer Medical Research Institute and the Queensland Institute of Technology, appearing via videoconference. Thank you both very much for being here today. In no specific order, Professor Mackay would you like to make on opening statement and then Professor Yates?

Prof. Mackay: Thank you very much for the opportunity to appear before this committee. As you mentioned, in May this year I took up my new appointment as Director and CEO at QIMR Berghofer. I have relocated from Melbourne. My research specialisation is immunology, which is very relevant for COVID. First I want to congratulate the government and Queenslanders for the outstanding state effort in controlling the spread of COVID-19. As a former Victorian, as you can imagine, I feel very lucky to be a new Queenslander.

I will let you know about QIMR Berghofer. It is a medical research institute. It is a 75-year-old institution that is doing world-class research in cancer, mental health, infectious disease and chronic disorders. The institute has a strong legacy in and international reputation for addressing various historical outbreaks in Queensland, such as Q fever, dengue, Ross River virus and parasites such as malaria. We have a strong history of tackling infectious disease. Therefore, it is not surprising to hear that we have been very quick at rapidly joining the international effort to tackle COVID-19. There is a good reason for that. It is because the institute has one of the rare biocontainment facilities, which really allows us to manipulate and grow safely very dangerous agents such as COVID-19. It is what we do.

When I first came here, it was very pleasing to see the spectacular progress done with the vaccine candidate at the University of Queensland, but the reality is that we are months away from an effective vaccine that can be distributed at scale in Australia and in Queensland. Therefore, our institute has decided to tackle something slightly different. It is really trying to find ways of helping sick people because, when you have a pandemic, no matter what it is, the first thing that you will have to address is trying to save the lives of the people who are critically ill from the infection. We have decided to do research to tackle that. I can give you a few examples of the things we do.

We are trying to stop the virus from infecting cells in the body. We are testing a number of inhibitors. Some are very successful at the moment and we are fast-tracking them to do clinical trials. We are also developing new immunotherapies, because one thing that happens with COVID is this catastrophic chain reaction that is really driving the immune system into override and inflammation. That particular process can be fatal in many people. We are also trying to stop long-term damage. I am sure you have heard that there are a number of concerns about long-term cardiac, kidney and brain damage following COVID-19 infections. Here at QIMR Berghofer we are growing human cardiac organoids, which we infect with COVID. We are finding a lot of agents that can protect the cardiac tissue.

As a final statement, something else that I want to share is that our institute is currently undertaking a comprehensive review. Not surprisingly, COVID-19 will be centre stage of the discussions as part of the review. It will certainly help realign the institute around its traditional and historical strengths in fighting infectious disease. Really the ambition is to be ready today with the new treatments and methods of care for the pandemics of tomorrow. Thank you very much. I am happy to answer any questions.

CHAIR: Thank you very much, Professor Mackay. Professor Yates, would you like to make an opening statement?

Prof. Yates: Thank you very much for this opportunity. I would echo Fabienne's comments about congratulating the government and the Queensland community on what we have achieved so far. I would like to follow up with a couple of reflections from the university's point of view on what we have learnt and some of the important collaborations that we have developed with Queensland Health and with other university and research partners as a result of the pandemic, which I think are things that we want to take forward as lessons.

As you are probably well aware, QUT's Faculty of Health is a very large provider of education for many disciplines in the health workforce. One of the things that we had to do very rapidly in March this year was turn our education online, just as schools did, so that we did not delay the progression

of our students in terms of their graduation and ensuring that we are preparing a health workforce to meet the needs of the system next year. One of the great things that happened with that was the partnerships that we developed with Queensland Health in terms of their support to continue to enable student clinical placements. That was not possible in all cases across all disciplines because, for safety reasons, not all students would have been able to have the level of supervision and support needed. However, we did not skip a beat in terms of continuing to have nursing students, for example, undertake their clinical placements. It was a wonderful collaboration between the university and the health system in terms of how we prepare our students and in terms of how students were supported.

Also, we were thinking differently about the worst case scenario if we really did need a surge workforce. We were be able to work with Queensland Health to identify students who might be willing to be part of that surge workforce. We were well prepared to partner and support the efforts to manage the pandemic should it had been worse than it was. Fortunately that was not required, but it really showed that in Queensland we have fantastic collaborations that enable us to respond in very quick ways. Those are the sorts of things that I think we should continue to learn from.

At QUT we have student clinics that offer services that complement some of the Queensland Health services. For example, we offer an optometry clinic and high-risk foot clinic. We did not want to stop those services to people because we knew that they might not be able to access services within the Queensland system, which might have meant their treatment was delayed. Like many places, we started to leverage telehealth services within our clinics. We learnt a great deal about how we were able to make health care much more accessible. Again, those are important things that we do not want to go back from. We found that that also enabled us to teach our students and prepare them to be more ready for the modern healthcare system in terms of their use of technology.

Fabienne mentioned research and I want to make a couple of comments about the research efforts and what this has enabled to us do across the Brisbane area, in particular, and also with collaborators interstate. We have realised that the research effort in treating COVID-19 and our response to COVID-19 have really required collaboration across a range of research institutes and across of range of disciplines. QIMR Berghofer, the University of Queensland and other partners, including Metro North and Metro South, are members of the Brisbane Diamantina Health Partners group, which is an academic health translation research centre. Through those collaborations across Brisbane we have been able to share ways in which we can work together on research efforts. In fact, next week the Brisbane Diamantina Health Partners is holding a forum where we will be sharing learnings from research that is going on and looking at how we are translating that research into practice. There will be a report on that forum next week. The leaders of BDHP are getting together to have a reflection. If the committee is interested, I am sure that we would be very happy to share the outcome of that report with you.

The last thing I would mention is QUT's research effort. In addition to the biomedical research, a really important part of our research is the systems response at a health system and community level. QUT is very strong in its health services research. We have a [Centre for Healthcare Transformation. As part of that centre we undertook a survey of frontline healthcare workers. We replicated a survey that was done in the NHS. That NHS survey of frontline healthcare workers was really about identifying the things that we have learnt from our responses that we do not want to give up, that we do not want to go back from. We replicated that.

I will mention some of the key findings. We asked frontline healthcare workers—and we had 239 responses across a range of disciplines—what are the sorts of important things that they did not want to go back from. The main things were things about the use of 21st century tools. There was a lot of comment about how telehealth and other virtual sorts of care models enabled the continuation of care in ways that were acceptable. There were some questions about how we make sure that we undertake further analysis of how we build on those learnings and make sure that some people do not miss out from access to technology in those services. That was a big thing. Another big thing that people commented on was teamwork. A lot of responses described examples of how teams came together to address issues in very productive ways that valued different team members' contributions that people felt they had not experienced before.

Some of the challenges that people identified in the survey were the recognition of the rapid decisions that needed to be made, particularly about reducing non-urgent services and how we might learn from some of those lessons that were done well in our response at this time. Other challenges were about the impact of isolation on communities and patients, the concerns that people have for people's mental health and how we need to be perhaps more proactive in identifying how we can respond. There were also some comments about the challenges about the coordination of communication in these very rapidly changing times. There was a recognition that, while people did

their best, we might be able to use some of our learnings to reflect on that. We are just analysing that data and writing it up. Again, hopefully in the next month, we will have a report that we are happy to share.

CHAIR: Thank you very much, Professor Yates. You have probably answered my question. I was going to ask if we could have a copy of that research. That would be appreciated as we look to report on the COVID health response in Queensland. You have also answered my question about collaboration. It was a meeting of minds, so to speak.

Prof. Yates: It was great, yes.

CHAIR: Everyone working together to overcome this pandemic with a vaccine and research is absolutely vital. Fabienne, I think you have joined the committee recently and provided advice around research on vaccines. I think I have asked you about the studies on cardiac tissues. You have been with us before, I am sure of it.

Prof. Mackay: That is right. I think (inaudible) Australia was running a (inaudible) session to provide information to a similar committee on a hearing about the progress of the research. I want to thank Patsy for covering the collaboration. It is very true. She is absolutely correct that we are all on board together to find solutions. We are providing our facilities to all our collaborators around Brisbane and Queensland. We have activity with UQ and QUT. I think that is a fantastic response as is the great level of engagement that everyone has demonstrated.

I will return to cardiac tissue. It is more and more evident now through large-scale infection in the United States, Europe and probably Melbourne that even if people recover from the infections they are likely to suffer long-term cardiac issues. There is a good reason for that. Because the receptor the virus recognises in the body is expressed in the cardiac tissues, it is expressed in the kidneys, it is expressed in the brain. That is why some patients lose their sense of smell and taste—because the virus recognises something in the central nervous system.

James Hudson is a brilliant researcher at QIMR Berghofer. He has put together this fabulous mini organ culture system of human cardiac tissue which can actually beat in the Petrie dish. It is really interesting. His job is really to infect that with COVID, and when he does that he sees that the cardiac tissue is not doing well at all and it is not beating the way it should. Then we are experimenting with a lot of different inhibitors to see whether we can protect the cardiac tissue from the damage from the virus but also from the cytokines.

Something that you have probably heard in the press is that the virus is capable of triggering a massive inflammation reaction in the human body. Those are basically factors that we normally do at low levels, but in this case they are produced in an absolutely industrial load and they are creating real problems in the entire body. It is just shutting down a lot of organs. It is actually causing death in many patients. So we are trying to stop the effect of that inflammation on damaging the cardiac tissue, and James has made a huge amount of progress in that direction. He has identified inhibitors and potentially a target that we can explore. We are making progress very fast.

CHAIR: Thank you very much. It looks like we have technical issues. We have lost the visual of our deputy chair, which puts us in a bit of a difficult situation. We are just trying to get him on the phone. With regard to telehealth, Professor Yates—he is back now—were you aware that federal funding runs out in September for current telehealth services? How critical is that if we are to continue that with this pandemic?

Prof. Yates: I think it is one of those things that we absolutely have to have with proper funding models for these services. I think that does need to be ongoing. We obviously need to have those funding models that are sustainable because this is the way to deliver care in the future. It enables us to give patients access to care that they might not otherwise get. It saves out-of-pocket expenses so people do not have to go and park at clinics et cetera. There are just so many reasons telehealth is an effective model of care that can still achieve good quality care, but it is not for everything. Whatever funding model we need to sort through, we do need to make that happen. It is just a part of our care delivery going forward. Whatever we need to do to make that happen, it also needs to be sustainable.

One of the comments that I would make is that the funding model must ensure that some people do not miss out. Some of the challenges we do have with technology enabled care is that sometimes there are groups in our community who are not as literate around technology, and for that reason they will miss out. I am not aware of the funding model, but thank you for raising that point. It is critical.

CHAIR: That was raised by Asthma Australia in their submission and we have spoken about that. A number of witnesses today have raised concerns around that and the need for it to continue for a myriad reasons. We have the deputy chair back now. I think Professor Yates touched on a collaboration. A committee had been established and you were looking to report on research at some point in time. I guess to better inform the health committee of current research, if any of those reports or findings could be passed on to the health committee we would certainly appreciate it in that important area of research.

Prof. Yates: Indeed. The Brisbane Diamantina Health Partners established a research collaboration through the NHMRC. Yes, we did actually have our board meeting yesterday and Fabienne is on that board as well. We did discuss the fact that we have this forum next week to share ideas, and the board was very happy for us to offer the opportunity to provide a summary report from that early next week.

CHAIR: Excellent. Thank you very much. I will open it up to questions.

Mr O'ROURKE: Thank you for being available this afternoon. My question is to Professor Yates and it is just around telehealth services, particularly in Central Queensland. We have issues about having various specialists available. What do you see are some of the key obstacles and barriers to the expansion of telehealth services as a key platform for providing mainstream health services in Queensland?

Prof. Yates: Some of the main barriers are the infrastructure, but the infrastructure is actually not that expensive. There are many, many video enabled systems that are already part of our mainstream system. There is some typical infrastructure that people need, but essentially that is not the main cost associated. I think the other issue goes to preparing our healthcare professionals. It is a different set of skills when you engage and do your clinical assessments in a virtual way. We do need to give our healthcare professionals confidence that they have those skills and we need to train them. We are looking to integrate that very much in core parts of all undergraduate training so that graduates are actually prepared in delivering these modes.

Of course, there are community issues. It is really about the community feeling confident they are going to get the same quality of care and service and, for those people who may not be as competent, particularly with the use of technology, that they are also able to be supported so that technology is made simple, that there are defined ways in which they can access those services with that support. I think they are at multiple levels, both the infrastructure and the system. It is even as simple as having private rooms in our healthcare settings, which is sometimes difficult. There are some infrastructure barriers. It is about the barriers that face competent and skilled healthcare professionals, as well as the community, and how we support them.

Mr BERKMAN: Thanks to both of you for joining us this morning. I wanted to ask a question of Professor Yates. Obviously, continuity in providing course work to students is a challenge, and one of the key challenges is ensuring that examinations can continue. I know that is particularly the case for medical students, given that accreditation requires the individuation of a substantial number, if not all, of the exams that students sit. I know this has been a particular issue at UQ around the use of ProctorU, but my understanding is that QUT has not had to use ProctorU or an analogous program. I am curious to know how it is you have gone about maintaining examinations in the way necessary for accreditation, and what are the alternatives to using that kind of online individuation and all the problems that come with that?

Prof. Yates: That has been the subject of lots and lots of conversations. There are multiple ways. Yes, we did not use ProctorU, but we have not dismissed it from being something that we may use in the future. At this point in time we found that we did not need to because we did many other things. First up, we thought about our assessment approaches. We looked at whether there are other ways to assess and still be confident that our students have achieved the learning outcomes they are supposed to. In some areas that was possible. Obviously in other areas, such as things like clinical skills and things where you do have to observe people demonstrate they are competent in practice that was not possible. When restrictions were relaxed a little bit and we were able to bring students back on campus, we did that in a way that was still within those restrictions, but it meant we had more classes. We used our bigger rooms. We ensured there was social distancing. Part of that was actually an opportunity for us to build our students' learning about their important role as public health advocates in whatever discipline they were in.

We thought about different ways. We reorganised things. We deferred some assessments. Essentially, we did manage—because we were fortunate enough that the restrictions were relaxed—to have all of our assessments achieved without having to use some of that other software. Certainly,

this is a new and growing field in higher education, and I think there will be lots more technologies developed and other services. One of the things that all universities have learned is how much more we can do online using technology. Again, we will not be going back to the same ways of teaching either. I think we will be exploring many, many more different options around technology and services to offer more flexible online learning. It was really a matter of having frameworks while still ensuring that the quality of assessment was absolutely the fundamental thing. It was the criteria that we used for judging whether or not an alternative method of assessment was still going to achieve that outcome.

Mr McARDLE: Thank you both for being here today. I really only have one question, and it relates to Professor Mackay's final point: a centre for infectious diseases control and pandemic preparedness. I wonder if you could both pass a comment on my question. We have now had very close to us a series of pandemics and other developments in relation to viruses and the like, including bird flu, avian flu, SARS and H1N1, and there are thousands of unknown viruses still out there that have not jumped or mutated. This is the first occasion on which Australia has been visited since 1918 on this magnitude, leaving aside the other influenzas that have occurred in the 1950s et cetera. The centre for infectious diseases control and pandemic preparedness I assume refers to a Queensland based initiative. Would it not be more appropriate to have a national body of that nature—or maybe we do have one already—a bit like the American centre for disease control? Pandemics do not stop at the border, and would it not be more appropriate to have a central body looking at this going forward, if the risk—which I suspect which is higher now than it ever has been in the past—were to repeat itself?

Prof. Mackay: I totally agree. If it was to become a national entity I think it would be the best outcome, because you are absolutely right. This is not to serve a local interest: it is to serve the future and the safety of the nation. That is what other countries like the United States have done. The thing is, you need the centre of excellence to be the driver of the partnership. This is not going to be something that can only be QIMR Berghofer. You have to work with universities that can handle that. You have to work with hospitals not just here in Queensland, but eventually a network around the country. You need to start at a spot where there is at least 75 years of expertise in dealing with these things popping up in the community, because you know you have this legacy and strong tradition of experience in that space. You start somewhere, but certainly the ambition would be to make this a much more effective integrated entity that would serve the entire nation. I agree with you.

Prof. Yates: Yes, I agree with that.

Mr McARDLE: The one place that strikes me is the TRI at the PA Hospital, which is, of course, discovery to application. That is not quite as broad as you are talking about. Would that not be an appropriate place to commence because there is a lot of collaboration going on there already?

Prof. Mackay: We collaborate with them too. I think the collaboration is not just within TRI. In fact, we meet with Scott Bell, who is the head of TRI, on a regular basis to discuss interaction between QIMR Berghofer, various universities and the things we can do together and other institutes like the Mater, so it is not one entity. Everyone collaborates.

Prof. Yates: TRI is a facility that cohosts researchers from many of our key universities in Brisbane such as UQ and QUT. In addition, TRI is a member of Brisbane Diamantina Health Partners. We actually do have a pretty good landscape of collaboration around South-East Queensland, and I think situations like this really show what potential we have in terms of medical research going forward as well across a whole range of areas.

CHAIR: In the time remaining, about one minute, I want to pass on our thanks. Quite often it is the front line. We have had police, the Chief Health Officer and everyone else contribute to our inquiry. The research is absolutely pivotal and vital in helping navigate our way out of this global pandemic, and I just wanted to put on the record our thanks for the research being conducted at QIMR Berghofer, the University of Queensland, QUT and all of you involved. It is very important and critical work. We appreciate it and we look forward to receiving updates on the collaboration that you have formed. Congratulations on the work you have done to date. Thank you for your time today. I now declare this public hearing closed.

The committee adjourned at 2.01 pm.