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
Mr BL O'Rourke MP (via videoconference)
Ms JE Pease MP

Staff present:

Ms L Pretty (Inquiry Secretary)
Ms A Beem (Assistant Committee Secretary)

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

TRANSCRIPT OF PROCEEDINGS

TUESDAY, 23 JUNE 2020

Brisbane

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The committee met at 10.59 am.

CHAIR: Good morning, everybody. I now declare this public briefing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee open. I would like to start by acknowledging the traditional owners of the land on which we meet on today. Today's proceedings are being conducted here live and also using Zoom, so I ask all of our participants and anyone watching the live broadcast to please bear with us if we encounter any technical issues.

I am Aaron Harper, chair of the committee and the member for Thuringowa. The other members of the committee here with us today are: Mark McArdle, via Zoom, the member for Caloundra and deputy chair; Michael Berkman, the member for Maiwar; Marty Hunt, the member for Nicklin; Barry O'Rourke, also on Zoom, member for Rockhampton; and Joan Pease, the member for Lytton.

The purpose of today's briefing is to assist the committee with its inquiry into the Queensland government's health response to COVID-19. This briefing is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. The committee will not require evidence to be given under oath, but I remind everyone that intentionally misleading the committee is a serious offence. Hansard will record the proceedings and you will be provided with a copy of the transcript. This briefing is being recorded and broadcast live on the parliament's website. Provided you are not joining us this morning via Zoom or your mobile phone, I ask everyone participating today to please turn your mobile phones off or switch them to silent. I also ask that you please place your microphones on mute unless you are speaking. This will prevent audio interference and background noise.

BOWLES, Mr Russell, Commissioner, Queensland Ambulance Service

CHINERY, Ms Tina, Acting Chief Executive, Cairns and Hinterland Hospital and Health Service (via videoconference)

DRUMMOND, Mr Shaun, Chief Executive, Metro North Hospital and Health Service

DWYER, Adjunct Professor Naomi, Chief Executive, Sunshine Coast Hospital and Health Service

PHILLIPS, Ms Barbara, Deputy Director-General, Corporate Services Division, Queensland Health

STEELE, Mr Nick, Deputy Director-General, Healthcare Purchasing and System Performance Division, Queensland Health

WAKEFIELD, Dr John, Director-General, Queensland Health

YOUNG, Dr Jeannette, Chief Health Officer and Deputy Director-General, Queensland Health

CHAIR: Good morning all, and welcome. In view of the briefing today being broadcast via Zoom, I ask that you please identify yourself by name when speaking, particularly when speaking for the first time. Committee members will also endeavour to ensure they clearly identify themselves when asking questions to minimise any confusion. This will also assist Hansard in their transcription of the proceedings. Dr Wakefield, I will now invite you to make a brief opening statement on behalf of Queensland Health, after which committee members will have some questions.

Dr Wakefield: Thank you, Chair, and good morning. I would like to start by paying my respects to the traditional owners of the land on which we meet today, the Turrbal and Jagera people, and their elders past, present and emerging. As the chair indicated, my name is John Wakefield. I am the

director-general of Queensland Health. I would like to thank the committee for the opportunity to brief you today on the Queensland government's response to COVID-19. Without further ado, I might ask if the chair is happy for Dr Young, Queensland's Chief Health Officer, to provide a brief opening statement.

CHAIR: Thank you, Dr Young.

Dr Young: Thank you very much, Chair; thank you, Director-General. I would also like to start by acknowledging the traditional owners of the land upon which we meet here today, the Turrbal and Jagera people, and pay my respects to elders past, present and emerging. I would also like to acknowledge the enormous work that has been done by our discrete First Nation communities in this state to manage their response to COVID-19. Not one of those communities has had a case to date, due to the work they have done.

Thank you very much for this opportunity to give a brief opening statement to the committee today about the Queensland government's health response to COVID-19. I would like to start by addressing the current global situation relating to COVID-19. Last night the director-general of the World Health Organization advised that there had been the largest increase in cases for a single day on 21 June, with over 183,000 cases reported. Today in the world there are now more than nine million people who have been infected with COVID-19. Sadly, more than 469,000 lives have been lost as a result of COVID-19, which makes it one of the most widespread pandemics in over 100 years. On 19 June the World Health Organization announced that it had received the highest number of reports of new cases globally in a single day and declared that we are in a new and dangerous phase of the pandemic.

Here in Queensland our response to the pandemic has been swift. We took steps early and set a goal right at the start to find, isolate and test. Our public health units have absolutely excelled in contact tracing. A cross-agency workforce was mobilised to support our quarantining arrangements in Queensland and we put in place an enormous testing capacity. In Queensland we are now able to test up to 10,000 people per day, and most of those tests are turned around in 24 hours.

Today in Queensland we have had 1,066 positive COVID-19 cases. Today in Queensland two of those 1,066 are active cases, with one of them currently receiving treatment in hospital. Unfortunately, six Queenslanders have died of COVID-19 to date. Two of them died while interstate. Five of the six acquired their infection on a cruise ship, and I do of course extend my deepest sympathies to every one of those people's families. In Queensland, in the current fortnight ending 22 June we reported two newly infectious cases out of 70,000 people who were tested, and they did not arise through community transmission in Queensland. We have now conducted over 327,530 tests since 22 January this year.

Comparing our response in Queensland to other states' responses is difficult. We know that Queensland has some unique geographical challenges compared to some of our other states that are quite compact, such as Victoria. Perhaps if I compare our response to that of New Zealand. It is possibly a reasonable benchmark, given their population is a bit smaller than ours. They too have a dispersed population, a bit like ours in Queensland, so I will compare those two. Queensland has had a total of 1,066 cases compared to New Zealand, which has had a total of 1,513—a total of 447 more cases. We have had six deaths, and of course every one of those I would prefer not to have happened. We have had six deaths, equating to a rate of 0.11 per 100,000 people. New Zealand has had 22 deaths, or 0.44 per 100,000 people. I might suggest those numbers show that we have done very well in avoiding a lot of that morbidity and mortality here in Queensland, particularly when we look at places like the United States, Spain or Italy.

But we cannot be complacent. The job is not yet done. Until we have an effective treatment or a vaccine we have to be very, very cautious. We must continue to be vigilant, to ensure that the hard work done by all of Queensland—all 5.1 million Queenslanders—and their sacrifice to date is not undermined. We must continue to all work together to protect the health of all in Queensland.

Our response has been challenging, and we have had to make some very difficult decisions to ensure that Queenslanders' lives were protected. While protecting the health of Queenslanders has, of course, been the primary goal of our response, we have also had to consider the impacts to the economy, to individual businesses and the enormous social impacts that the response has had on Queenslanders. Those are matters that none of us have taken lightly. I, of course, never took lightly the restrictions that I had to impose on people in relation to some very significant events, particularly funerals, and also the requirement for people to postpone other major life events such as weddings, significant birthdays and other celebrations.

Other issues greatly concerned me and many of my colleagues. Suspending certain non-elective surgery was very difficult and suspending the BreastScreen service was particularly difficult, but none of this was done without careful consideration of the impacts and the necessity for why it needed to be done. I do want to take this opportunity to acknowledge and thank every single Queenslander who has made a sacrifice to support our response to COVID-19 in this state. As a result of all those efforts and everyone's contribution to the response I know we have saved Queenslanders' lives.

We understand that the response has completely changed the way we work, socialise and carry out our day-to-day activities. We acknowledge that we did not have a significant amount of time to prepare or ease into those restrictions, as of course we would have preferred to have done, because we knew that every single delay could cost lives and have catastrophic consequences. We needed to act very quickly so we could stop the spread of the virus before it became unmanageable. I am sure you have seen the UK's response and how many people there have said that if they had just closed their borders a little bit earlier, how many more lives they would have saved. We did not have time to consider our response in the way that we would normally consider the major decisions that were being made, but I would strongly suggest that because of what we have done to date we are now able to start and more rapidly ease restrictions so that Queenslanders can return to their day-to-day lives whilst still limiting the risk of COVID-19 spreading throughout our community.

Reflecting on where we are now and the achievement of how we have effectively suppressed COVID-19 in Queensland and how it has not only saved many lives, initially the modelling suggested that 12,500 Queenslanders would die in the first wave of the pandemic if we did not mitigate it. I also think that we have strengthened our community's confidence and that they will be able to go out and resume their normal lives. While the easing of restrictions has been difficult because people have not understood the time frames and why some industries have been able to get up before others, it is important that we do it in a considered way and that we continue to evaluate what we have done. We must prevent a second wave. We know that a second wave will always be worse than the first wave because people are very reluctant to go through what they went through the first time all over again. We know that we would struggle.

Going through a bit of the time line, it has actually not been very long since this all started. In mid-January we were first told that there was a new threat emerging in Wuhan, so on 22 January, after receiving that information from the Commonwealth, I declared a public health event of statewide significance in relation to the emerging threat of COVID. This meant that I could work with all of the hospital and health services to mitigate the impact on Queensland. On 25 January I stood up the State Health Emergency Coordination Centre, and it has been stood up ever since.

On 29 January the minister, now also the Deputy Premier, declared a public health emergency under the Public Health Act 2005. We were the first state in Australia to take that action. Our proactive approach has proven to result in exceptional results in that it allowed emergency officers to respond to the public health risks primarily by empowering them to issue self-quarantine orders at airports and wherever the need arose across the state. With hindsight, it was extremely fortunate that we took that action. At that stage, given the advice we were receiving, we thought that you could only transmit the infection when you had symptoms. We now know that you can transmit the infection for up to three days before you show any symptoms and, in fact, you are most infectious in the 24 hours before you have symptoms. We did not know that at that time, but we put in place very strong quarantine orders in Queensland and that has stood us in such good stead.

The director-general initiated some very early health system planning that enabled us to triple our emergency department capacity and double our intensive care unit capacity. Pathology Queensland established early expanded testing capacity for COVID-19, way ahead of other states. That really stood us in good stead. The quarantining and the early testing are what I think have made a big difference here in Queensland.

We had our first case on 29 January. From 2 February we started screening at our international airports in Queensland, of which we have three. That was an enormous impost. Here today is Shaun Drummond from the HHS that bore the brunt of that. He did an absolutely amazing job at managing Brisbane International Airport.

Our network of public health units are spread across the state of Queensland. Unlike some other states, where the units very centralised, in Queensland they are spread across the state. The units rapidly mobilised to ensure that we had the key elements of an effective response in place locally throughout our state. Our contact tracing and finding people who were potential cases, isolating using

quarantine to make sure that they were genuinely isolated—that it was not optional for people but they had to be in isolation—and our testing strategy was very swiftly established early on. We had already done the work.

On 11 March the director-general of the World Health Organization declared COVID-19 a global pandemic. As I said, in Queensland we were already well advanced to respond and we were already considering the next stage of our response. We were way ahead. On 18 March our parliament passed amendments to the Public Health Act to ensure we had the legislative tools to effectively respond. Changes included putting in powers so that, in my role as Chief Health Officer, I could make public health directions. That was critical because, as I said early on, it is about the rapidity of the response that is needed. You have to make the decisions quickly and implement them quickly. There is not the time to go through the usual well-tested process that I hope we would normally use. There just has not been time for that.

Those public health directions have enabled the mechanisms to put in place all of the various social distancing policy measures that we have used in Queensland to enormous effect. As of 23 June I have made 64 directions and three notices. Today there are currently 17 of those directions and two notices in force, with 47 directions and one notice having been superseded. The directions have allowed us in Queensland to respond rapidly to the emerging threats and issues that have arisen. Without them we could not possibly have implemented the social distancing measures in the time frame that was needed. I absolutely would like to acknowledge those within Queensland Health and across the entirety of government who have worked tirelessly to support the development and implementation of those directions. They have been so critical to our response.

In preparing our hospitals to respond to COVID-19, having looked at the evidence coming out of China early in the pandemic earlier this year, we were able to develop a picture of what might be required if a worst-case scenario were to occur. We started our planning based on around 20 per cent of our population, or one million Queenslanders, contracting the virus in the first wave, which we thought would last around six months. We estimated, again based on the information out of China, that 80 per cent would get mild disease, not requiring hospital treatment; 20 per cent would need to be hospitalised, so 200,000 people across the six months; and five per cent, or 50,000 people, would need intensive care and probably ventilation. Estimates of deaths were very unsure at that time. They varied from around one per cent, or 10,000 Queenslanders, up to three per cent, or 30,000 Queenslanders.

That first modelling suggested that the first wave would really start to escalate in late April, peak around two to three months later and gradually reduce. The Queensland government allocated an additional $1.2 billion over the 2019-20 and 2020-21 financial years to support the health system to cope with that expected wave. Without that support we would have been overwhelmed and we would have seen the outcomes that we are still seeing today across the world in countries that were not able to prepare. The capacity increase included tripling our emergency department capacity and doubling our intensive care capacity. We know that if we can get people into intensive care we can save their lives. In China they saw around half the people they ventilated die. Here we have seen one out of 15 whom we ventilated die. I do not underestimate the impact of that death on that family, but we had another 14 families who did not have to mourn one of their relatives.

We have worked very hard to ensure that we had sufficient supplies of personal protective equipment, PPE, to protect our frontline staff at a time when we had critical international shortage. I think we were successful. To date in Queensland we have had two healthcare workers acquire COVID-19 at work and neither of them were due to lack of PPE. They acquired their infection from another work colleague in the workplace. Our staff had adequate supplies of PPE and also adequate training—very good training—which is not the response we have seen elsewhere in our country and definitely not what we have seen overseas.

We also increased the number of ventilators available, because it would be appalling if any Queenslander could not be ventilated because we did not have sufficient ventilators. We do have sufficient ventilators in Queensland. To illustrate the impact of the market and the international supply challenge to source all of that PPE, a simple surgical facemask, which used to cost 60 cents, is selling for $6. However, the work had to be done to ensure that our staff had PPE when and where they needed it, and we were successful. To give you a picture of what has happened, some of our colleagues in other states had over 100 healthcare workers acquire COVID-19 in the workplace through their work.

Throughout the testing response we have very carefully monitored all of the data to ensure that our testing criteria were aligned or, in many cases, exceeded the minimum levels agreed at AHPPC and national cabinet. All along we have enabled our clinicians to test outside the case definition,

because we had the capacity. Other states did not have that capacity, so they had to rigidly control who could be tested. In Queensland, because we had that capacity right from the word go, we were always one step ahead. When the nationally agreed position was to test people only from China, we were testing a broader group. When it was to test only certain symptoms, we were testing a broader group. Now we can test up to 10,000 samples per day.

The hospital and health services have done an absolutely amazing job at establishing fever clinics very early on, in very challenging circumstances, to ensure people could rapidly and easily get tested. They also ensured that we separated those who potentially had COVID-19 from the emergency department, so that other work could continue.

If we look at contact tracing, the hard work and absolute dedication of our public health units and our contact tracers across the state has been, in my mind, one of the key elements to the success in our response to COVID-19. We very rapidly increased our contact tracing capacity. In addition, we drew on other government agencies and they provided staff we could train in contact tracing work. That has been critical. At no stage have we not been able to contract trace to the extent that was needed. Those contact tracers and our public health units are the front line in identifying those who might unknowingly spread the virus to others because, as I said earlier, we have now discovered that people can transmit the virus up to three days before they have symptoms. That is why contact tracing and getting those people into quarantine well before they have any symptoms is so critical.

It has been unfortunate that Australians have chosen not to download the COVIDSafe app. At this stage, less than one quarter of Australians, or 6.3 million people, have downloaded the app. Of course, not every Australian has a smartphone, but 16 million do. Of those, 6.3 million people have downloaded the app. Hopefully we will never need it. Hopefully we will have so few cases to contact trace that we will not need to have the app. I am told by my colleagues in Victoria that, despite them having large numbers of cases in the past week—they have had 116—to date they have found only one person through the COVIDSafe app whom they did not find through the contact tracing process. The COVIDSafe app was very important at the time when case numbers were escalating, but it is less important now. However, I still think it would be a very good thing. It would be an added tool that would benefit us if people were to choose to download it.

Lifting restrictions has been a challenge. The stage 2 lifting of restrictions represented a significant opening up of many sectors. It has been vital that we work closely with the relevant industry groups to navigate the pathway between opening up and ensuring maintenance of public confidence, the continued suppression of COVID-19 and enabling increased economic activity. That has been a fine balancing act but a very important one.

Queensland Health continues to work with the relevant departments and the industry groups to support how we can maintain appropriate social distancing within a range of business settings using our COVID-19 safe checklists and our plans. A measured public health response to easing restrictions means that we can increase the number of people with whom people can continue to interact and the numbers of places where they can do that. We need to keep in mind the potential risk of multiple outbreaks across the state that could not be managed if we release the restrictions and we have more cases come across our borders into Queensland. It is vital that we ensure we minimise the number of new cases, because we know that one case into Queensland—as happened at the restaurant in Noosa—can rapidly lead to another 28 Queenslanders, so 34 people in total, getting infected.

Moving forward, we are continuing to monitor the latest health data from the national incident room, from the AHPPC, from the WHO and we are continuing to work towards our planned stage 3 of the easing of restrictions on businesses and activities on 10 July. We are, of course, also reviewing all of the epidemiological data to assess the processes happening at our borders—the international border, the domestic border and our internal borders. We need to remember that we still have internal borders in our state with those discrete First Nation communities. They are the three borders we need to keep in mind and keep working through.

Fortunately, elective surgery, cancer-screening procedures and our ambulatory services have all been able to significantly increase in the past two months and, indeed, many of our hospitals have now returned to pre-COVID-19 levels of activity. The Queensland government, of course, recently announced it would be injecting a quarter of a billion dollars into the health system to expand the capacity of elective surgery activity in Queensland hospitals, including working collaboratively with the private hospital sector. That will significantly, of course, reduce the number of people who are on our elective surgery waiting lists as a result of the COVID-19 requirements.

Some of the changes that we have put in place in the health sector will need to continue and some of them are excellent. Expanded use of virtual care is just brilliant for our state. I think some of the things that we have put in place for our more rural and remote communities will stand us in good stead for normal health care going forward. We intend to capture some of those new ways of working as part of creating the new normal health system that better integrates primary and hospital care, maximises the use of technology and takes more care out into the communities where people live.

In conclusion, I believe Queensland has done extremely well to proactively respond to the COVID-19 threat to our society. Without that proactive action we would not be here today talking about what has happened. We have seen how the virus has devastated and continues to devastate populations overseas when health systems just become overwhelmed with cases. I am proud to say that we avoided that scenario here in Queensland, but I do not underestimate the enormous sacrifices that many, many Queenslanders and Queensland businesses have had to make. We have a tough road ahead, but I think if we respond to those economic challenges and we continue to respond to the health challenges we will manage those challenges as well. Thank you very much, Chair and committee.

CHAIR: Thank you very much, Dr Young, and thank you for those opening remarks. We are indeed in a very enviable position in Queensland compared to other jurisdictions—we have already received some data around other jurisdictions and internationally—and it is because of that early response. I think we ought put on record on behalf of the committee our thanks to all of those thousands of staff. I know it is a whole-of-government response, but there is no doubt Queensland Health has led the way and the department: those testing clinics, those fever clinics, those nurses, the doctors, our paramedics that did all the training, the people that are responding on the front line. I find it remarkable that only two out of I think over 70,000 staff have contracted COVID compared to other jurisdictions. We thank every single person involved in the health response.

Dr Young, you have become the face of Queensland. You advise the Premier and government on all of those public health orders and what we ought be doing around border closures and we rely on that. The burden of responsibility must be enormous. We thank you for that. I have spoken with a lot of people in my electorate, particularly in the early phases where we asked our older Australians to stay home and we asked people to enforce those practical measures of 1.5 metres distance and hand hygiene, and the consistent feedback I got when we were doing welfare checks on those people staying home was 'thank you'—'thank you for leading the way and providing that certainty'.

I want to unpack just for a moment: where did Dr Young come from? You join all the other health officers and you advise national cabinet, but where did you start? What are your qualifications and how did you end up with this enormous burden of responsibility? A lot of people have asked.

Dr Young: First, I am one person in a team—a team that has just been unbelievable, a team of over 100,000 people. Queensland Health has done a brilliant job and it is not one person. I have been very fortunate to be in the position I am to have a team that knows what to do and got on and went the extra mile time and time and time again. That is why I think it has worked. Thank you for your very kind words, but it is a lot more than me and a lot more than Queensland Health; it is a whole-of-government response.

CHAIR: I knew you would say that, but how long have you been our Chief Health Officer?

Dr Young: I have been the Chief Health Officer here in Queensland—it has been an enormous privilege; I have been very fortunate to be allowed to continue to remain in this position—for 15 years. On show day in August it will be 15 years that I have been in the role.

CHAIR: We hope you get to have some time off on that day. Given you have been around for some time, you will be familiar with the SARS, swine flu and influenza pandemics. What work had already been put in place in relation to preparation and planning for a pandemic prior to COVID?

Dr Young: I have been very fortunate that those 15 years has been the time that Australia started planning for pandemics. I was involved right at the start when we were planning for an avian flu pandemic, which would have had enormous consequences if it were to happen. We did a whole lot of planning. We had Exercise Cumpstone here in the Brisbane Airport, where we actually exercised quarantining an entire plane of people who had come from an island where an outbreak of a disease happened. I must admit that Metro North, when they actually did it in real life, did it much better than when we did it in an exercise. When we did in it an exercise I can remember advising the then health minister, Minister Abbott, that I did not think we would be able to do it in real life. It just did not work. Metro North showed that it can work very effectively and they have done it time and time and time again.

I was involved then in exercising and in developing plans. I was part of the Australian Health Protection Principal Committee where we developed the very first pandemic plan for Australia. Then we went through the swine flu pandemic which, in hindsight, thank goodness, was a very mild disease. We have had continuing waves since then. We still get a wave every winter, but it is a mild disease. Even so, it had a significant impact. We looked at what we did and we evaluated our plans again. Since then we have had multiple other events that did not reach the threshold for being declared a pandemic but certainly tested our systems and made us look at them time and time again. Every time we looked they just got steadily better and better. We had MERS, Ebola and all of these other events that meant we could test them and manage them. Then last year—very fortunate timing—here in Queensland we reviewed our pandemic plan again.

By doing that continual reviewing, continuing to have those networks of people to talk to and practising, when it happens you have something that you can grasp hold of. The difficulty, of course, with this pandemic was that it was not the pandemic that we were expecting it to be. Although we had looked at other potential pandemics and how we would modify our plans, such as Ebola, most of our pandemic planning to date had been about flu. This was a coronavirus—very, very different. Although we could use a lot of those strategies, we had to rapidly amend the plan. We did that as a national committee. We sat down in Canberra and we worked through the pandemic plan for flu and turned it into a pandemic plan for coronavirus, and similarly here we looked at what we were doing.

CHAIR: My next question goes to what has occurred in Victoria over the last few days. Are you concerned about what is happening in that state in relation to transmission into Queensland in regard to border closures?

Dr Young: I am concerned. Victoria had a similar process to the rest of the country. We all agreed to close down quite significantly to gatherings of two people. Victoria put that all in place. Here in Queensland when we started removing those restrictions we had had quite a period without cases. We were in a good position to remove those restrictions. We lifted them stage 1; we lifted them stage 2. Victoria never got down to that same level. They still had active cases in their community—quite significant numbers of active cases—which made it very difficult for them as they were removing those restrictions because then they had ongoing numbers of cases and ongoing numbers of clusters.

In the last week, for instance, just to compare Victoria to the rest of the country, 83 per cent of Australia's total number of cases—so acquired overseas, in quarantine, and those sorts of cases never concern me; that is why quarantine is there—were reported in Victoria, with only 25 per cent of them in hotel quarantine acquired overseas, 29. The 87 remainder were associated with community transmission, so acquired in their community. We have always, as a group at AHPPC, thought that that tipping point would be really concerning. When more than 50 per cent of your cases are acquired locally in your own community you are in strife. If we think about here in Queensland, 80 per cent of our cases as of today have been acquired overseas or interstate; only 20 per cent have been acquired locally. That is a really important figure.

I have just received today's data from Victoria. Of their 17 new cases today, their Premier has stated that one is in an hotel, acquired overseas, in quarantine; two have been locally acquired from known outbreaks; three they do not know where they have been acquired; and 11 they feel were totally unknown. They think three could maybe have been acquired somewhere but 11 are unknown. They are struggling to find where their cases are. More and more of those cases are just popping out all over the place with no known cause for them. On Sunday AHPPC, all the chief health officers from around the country, met to work through what we could do to support Victoria, because we know that that is the risk to the country. Everywhere else in the country has had minimal, if any, cases in the last month or so, so really has managed to get on top of the pandemic. Victoria is the risk now for the rest of the country. As I said before, we know that just one case from interstate can rapidly lead to 34 cases in a local community.

Mr HUNT: Thank you for coming out today. I appreciate that your time is very precious at the moment. Congratulations on the results achieved in terms of the low levels of infection in Queensland.

I want to explore the directives—how they impact the health system and how they have impacted Queenslanders. We have had great results; however, Queenslanders have had to make a lot of sacrifices in this case. I will start with the health response plan that you provided, because it sort of feeds into what I was going to explore: the impact on the health system's other activities in terms of what we have had to cancel and what we have been able to do as a result of this. I will take you to No. 1: stop all urgent elective surgery and outpatient appointments. On the graph where it says ‘number of cases' there is no actual number there. Did we reach that point No. 1, the number of cases that triggered that, and what was that number of cases?

Dr Young: That decision was made by national cabinet based on what was happening across the country. All first ministers agreed at that point in time that we needed to stop elective surgery and create capacity to manage the COVID-19 response.

Mr HUNT: That was not a specific number of cases?

Dr Young: No, it was not. It was a decision made by national cabinet based on the epidemiology they were given.

Dr Wakefield: What we are looking at here is this graphic. The time we were planning this response was even before the national cabinet had commenced. We ultimately met with all of the health services and the department and key stakeholders in March to essentially try and put the information that we had: what would be the threshold for us to shift gear, if you like? No, there were no specific numbers there because it was not so much about the numbers of elective surgery cases; it was the particular state we were going to be on the curve. What was the growth of cases?

At that particular point in time we had worked on a number of metrics including, for example, what percentage of our workforce would have been infected with COVID and/or been out of the workplace quarantined or looking after family members. We roughly cut that to 10 per cent of our workforce. Twenty per cent of our workforce was the second wave, 30 per cent and so on. We worked up, to the best of our ability, the models and the thresholds and triggers. As Dr Young has said, with the advent of national cabinet and with more and a greater degree of data and modelling coming forward, national cabinet in the end decided that we were at a point of time when we had to create that extra capacity. The modelling that was in front of national cabinet at that stage showed, as Dr Young has already said, that we were heading for a very steep uplift in cases in late April. That is when national cabinet acted, and we acted at the same time to suspend what in actual fact was around 50 per cent of our surgical activity, which was the non-urgent category 3s. So 50 per cent of our surgery continued right the way through.

In addition to that, I think it is fair to say that we knew this was coming, and so for the month prior to that decision—I think it was around 26 March when we suspended elective surgery—we had spent the better part of the last four weeks way over production. We had spent a significant amount of resources working with the private sector and expanding our public sector to try and get ahead, if you like, because we knew that was coming.

CHAIR: Procedurally, we need to table the data that you are referring to on these documents. Is leave granted? Leave is granted.

Mr HUNT: In terms of cancelling elective surgery, I was privy to briefings early on where we were talking in really scary numbers—as you mentioned before, 10,000 deaths et cetera. In terms of preparing for that and cancelling elective surgery to build capacity to deal with that, we never sort of even came close to those levels, did we? What I want to explore is: if we kept those elective surgeries going to a point where 'it is starting to get urgent now', in hindsight could we have kept them going for longer? Did we have the capacity to keep them going? Did we really need those resources parked?

Dr Wakefield: I think there are two parts to that question. Hindsight is a wonderful thing. When these decisions were made, we were looking forward based on the information that we had at the time. I think Queenslanders expected us—and I think it was our obligation—to prepare for every scenario, including a worst-case scenario. In fact, the scenario that we prepared for was not the absolute worst-case scenario. There were worse-case scenarios than 20 per cent of the population infected in the first wave, for example. I think we used the data we had. We were very happy to be wrong, but if we had not been wrong then we—unlike Europe and the UK and America, where in many cases the developing world is less visible to all of us, I think—would have had potentially a health system overwhelmed with all of the consequences to Queenslanders and to our healthcare system. We had to prepare. Was the decision to suspend that amount of elective surgery the right decision at that time? I think my answer to that would be yes. With the information that we had in front of us, both nationally with the national cabinet and at the state level, it was the right time to do that.

The second part of the question was: did we not just have a whole lot of idle people, then, for a long time? The answer to that is no. We had to redirect a lot of our people towards planning. We trained around double our intensive care unit capacity. We had to train a whole lot of nurses and doctors in doing work that they were not normally used to doing. We had to redesign and re-spec spaces that were not traditionally intensive care unit spaces to take those beds. We had to direct staff into the public health units for a whole lot of work around case finding and case contacting, around the work out at the airports, around all the work that is probably unseen in some respects as it is not traditionally health and hospital work.

In short, the answer is that we are delighted that in fact, with the benefit of hindsight, we could probably not have gone so hard on holding back some of the work, but we needed to be ready.

CHAIR: Dr Wakefield, can I just get clarification that elective surgery was a decision by the national cabinet?

Dr Wakefield: The decision was made by national cabinet. It was articulated—I have the date here as 27 March, but I stand to be corrected. Then obviously the states have to enact those decisions as they see fit, but all the states, to my knowledge, pursued that decision.

Mr HUNT: What I was getting at, I guess, was the lead-in time, which you have answered. How much lead-in time and preparation was there? I am just unpacking that preparation, so that Queenslanders do not think surgeons were sitting around twiddling their thumbs with nothing to do.

Dr Wakefield: No.

Mr HUNT: I will move on to your directives. In the electorate office I found a lot of confusion around 'essential' and 'non-essential'. In fact, 'essential' is defined in law as anything not listed as non-essential. There was confusion even with the police issuing fines to people going to the tip—which were later revoked—as an example. There was confusion around what essential meant, even though it was defined in the directive. Was there a reason you used that particular language in terms of 'essential'? Was it to have people think about leaving home as it was, rather than just going by the legal definition? We received lots of inquiries around that.

Dr Young: With all of the public messaging I tried to simplify it for people, to actually use principles. We had to write directions in law because they are under the Public Health Act and they had to be drafted in a certain manner. In terms of getting the message out, we tried to do a lot of messaging. There was a lot of public information, a lot of social media going out trying to say to people, 'We need you to stay at home except for these four key things.' We did leave it to people to interpret in some ways, because in Queensland, for instance, we did not close all of our retail. Some of the other states did. We kept it going because I did not feel that we needed to close all of our retail, given the situation in Queensland and how Queenslanders were responding. But then the question is: is it essential to go and buy a new pair of shoes? Maybe if you are a child going to school, those sorts of things. So it made it harder, and there were some other businesses that were or were not essential.

Mr HUNT: I guess that is where some of the confusion in the community lies, because the use of the word 'essential' made people question whether they could do it when it was actually defined in law, which we had to keep pointing people to.

One of the biggest impacts on people obviously was the decision around funerals. Weddings, yes, but they can be postponed. Funerals are one of those things that cannot be postponed. I understand there was an application process for exemptions around that. Did Queensland Health get a lot of applications for exemptions around funerals?

Dr Young: Yes, I did. Every single one came to me.

Mr HUNT: Were exemptions made in particular cases?

Dr Young: Yes. I very early on made a decision—again, given the response of Queensland—that I would allow 20 people. The nationally agreed position was 10 people for a funeral, but I really felt that was causing so much difficulty for people and I could understand that. I felt with some mitigating factors that people put in place—and were very good about—that we could manage 20, so we did in Queensland go to 20 very quickly.

Mr HUNT: Did you authorise any other funerals above 20?

Dr Young: There were a few, yes. Again, national cabinet agreed that chief health officers could, in extenuating circumstances, make decisions, and I did. There were a few that I did allow more. There was one particular one in Mackay. Because Mackay at that stage had absolutely no cases the risk was minimal, so I allowed 80 for one particular Indigenous funeral.

Mr HUNT: What were the criteria you used? I am getting to fairness here, obviously. People would put in their exemption requests: 'How come they can have this? How come I can't have it?' What were the criteria that you considered around those exemption requests?

Dr Young: The main one was where the funeral was located. If it was in an area that had active cases I did not go beyond the 20. If it was an area that had no cases and they were not going to have anyone come from areas that did have cases, I allowed some additional numbers. It was mainly about what was going on. It was also about who was attending. Some people were getting people early on

who were coming from interstate, even overseas. That was a very high risk, so then I pulled it right back. It really depended on where the funeral was being held, who was attending and what reason they had. Some people might have a family with five children. There might be some definite reasons why. Then, it was about where they were holding it. Some people were managing funerals. They would have a certain number inside, then they might have an honour line maintaining a 1.5-metre distance between each person. I did not see that as a risk. Some funerals were going to be outdoors. That is why I turned my mind to every single request and tried to work out what was safe and what was compassionate for that particular family.

Ms PEASE: I also thank everyone for the great work you have done protecting Queenslanders—both yourselves and all of the staff. My young niece Camile Johnston was a nurse at Redlands and now is at the PA. She has done a great job and I am really proud of her, as has my neighbour Sophie, who works at the PA. It is a good opportunity to give them a plug. I also want to talk about the PPE equipment. I am not sure if you want to answer this or hand it over to one of the executives from the HHSs to talk about. I know there has been some discussion around shortages and the supply chain—and this is another opportunity to give a bit of a plug to Brisbane Bayside State College and Iona College from Lytton who made 10,000 units and donated them to the Royal Brisbane and Women's Hospital. That is a really great achievement for those students from the tech department. What actions have you put in place to ensure there will not be shortages, and how are we going to protect the future?

Dr Wakefield: I might call on Barbara Phillips as temporary head of a new division that I formed called the supply chain surety division. Barbara can outline the key strategies we put in place.

Ms Phillips: It is an excellent question but, firstly, can I acknowledge and thank you for your appreciation for the staff and the work that has been happening. As you can tell, I have a New Zealand accent, but I do not allow that to get in the way. Being part of the Queensland response, I have been incredibly proud to see the staff who have enabled us to do what we have done—I would just like to thank them for that. I also thank Jeannette Young, who allowed us to have a small margin of buffer of PPE when we started this event. We would have certainly loved to have more, but Jeannette's prudent thinking ahead of time allowed us to have a very small margin when we started this.

Your question was around what we are doing to prevent shortages. If the committee will indulge me a little bit—I am not sure of your background knowledge of PPE. It has been an interesting ride to see how it has progressed. Certainly as the COVID event unfolded it became very clear that we had a very challenging environment not only within Australia but across the world in terms of what PPE was available to us.

We have been working incredibly hard to make sure that we have the appropriate PPE for frontline services, for staff, for public servants. We have put in place strategies to do that. The first thing we did was to get ahead of ourselves in terms of our ordering. We tried to get a 12-week ordering process. That sounds impressive until you realise that our fulfilment rate—of course, while you can order, it does not always guarantee that what you will get is what you have ordered. We found that our fulfilment rates were not high at the very beginning because obviously we were not able to bring things in from across borders, and borders were being closed as we were putting orders in.

We put in a strategy that, as I have said, centralised the procurement supply chain in its entirety. We brought together all of the contributing areas within the department to put that division together so we could work on a strategy that was end to end around procurement and supply. We have worked incredibly closely with our colleagues across the system, and I am very grateful for the work that the HHSs have done with us around supply. We could not have done this without them.

The strategies we put in place initially were to expand on our existing suppliers—make sure that we could get from our existing suppliers who are known to us more and more of the critical items we needed. We then looked at new providers that we could bring in to look at how we could encourage them to enter the market and provide us with those clinical items. Thirdly, and most importantly—and I think this is where you really saw Queenslanders doing the right things for other Queenslanders—we saw manufacturers who had no experience in terms of the critical items turn their hands and their businesses really quickly to help provide us with some of the things such as hand sanitisers and face shields—and we had people doing gowns—incredibly quickly to support us in those processes. We worked with other agencies as we did that.

In terms of how we are thinking going forward, it is challenging. One of the things that we needed to do quite quickly was work out what our critical list of items would be for PPE. We worked across multiple points, not only with clinical networks but also incredibly importantly with Jeannette's

team, in terms of what would be appropriate to put on that list and then how we could source that in a meaningful way. Some of the markets have opened. It is very gradual and then you will see things that actually stall at a low level. We are still struggling to get some items on that list.

What I can tell you is that currently we have approximately 90 days worth of stock sitting in our DCs for most of the items on the critical list. In terms of those ones of which we have lesser volumes, we are really applying ourselves to think about how we can innovatively source those items. Obviously not everything can be made here as we do not have some of the raw products and that is a real challenge for us.

Ms PEASE: I want to turn to some of the comments you were making earlier, Dr Young, with regard to contact tracing. I am interested to hear about the difference between how we handle contact tracing here in Queensland and what they are doing in Victoria, given the significant growth rates and lack of ability to find people in Victoria.

Dr Young: They are doing exactly the same. We are all contact tracing in the same way, which is once you have the case—that is the most important part; you cannot contact trace until you actually have a case. We started testing here in Queensland more broadly much earlier than Victoria and some of the other states. That stood us in good stead because we found the cases. Then it is a matter of speaking to the individual and finding out who they have been in contact with. That is what Victoria is doing now and that is what we have done right from the start. The most important part is to actually find the case; that is the testing.

Ms PEASE: Have you done any modelling on what would have happened if we had not managed our contact tracing to begin with and do it so well in Queensland, or does that go back to the original figures?

Dr Young: That goes back to that scenario about what would happen if 20 per cent of Queenslanders were to get it.

Mr BERKMAN: I will begin by echoing everyone's sentiments expressed earlier and thanking you and everyone in Queensland Health for all the hard work that has gone into keeping our infection rate so low. To start with, I want to touch on PPE briefly—not so much the procurement side of things but more the medical benefits and the impact that the use of PPE and particularly face masks can have on transmission. We know that the supply concerns have largely been dealt with and we are in a position now where face masks are more readily available. The advice on the utility for the general public to wear face masks has been a little unclear to me over time. Can you clarify for us what the position is now? What value is there in particular circumstances of the general public using them?

Dr Young: Face masks are absolutely critical if you are sick. That is really important. Right from the word go we have said to people—and indeed the Commonwealth provided masks through the primary healthcare networks to pharmacies, for instance, as well as to GPs so they could be provided to people who were sick; that is critical—they have to have a face mask on when they go to get tested and for that period of time going from home or wherever they are. That is very important.

In terms of face masks if you are well, it depends on the community you are in. If you are in a community that has widespread spread of the virus, then to protect yourself, if you can get them it is probably a good idea to wear them. You would see in the United States they are telling their community to wear face masks. There are some difficulties with accessing them, but if you have access to them it is then that people need to understand how to use them. It was interesting. I was told on the weekend about what had happened at our stadiums in terms of managing the increased numbers of spectators. At one of the stadiums the security personnel were beautifully wearing masks—around the wrong way.

People need to understand how to use them. We know that the virus will stick on the front of the face mask, so if you touch that when you take the mask off you can infect yourself. The other day I went to the Apple store to sort out my watch. There were people there just pulling the face masks down and up and playing with them. That is harmful if you have it on there. Our staff in Queensland Health clearly know how to use PPE, and that is why we have not seen cases amongst our staff who have been managing patients with COVID-19. Out in the general population people do not understand how to use masks. My advice is: if you have very few cases, there is no need to wear a mask at all unless you are sick and you are seeking health care. It is only if you are in a community where you have a large number of cases that you would need to wear one.

At the moment Victoria is advising people who have to use crowded public transport, for instance, that they might consider wearing a mask. I do not think in Queensland anyone needs to consider wearing a mask to protect themselves. We have two active cases. One of them is in the

Gold Coast hospital and has stopped shedding virus; they are recovering. They were in the ICU for quite a number of months and they are now recovering in the ward, so they are not infectious but they are still an active case. Our other case is in isolation and came from overseas, so they did not have any contact. We do not have active cases in Queensland today that people need to concern themselves with. If we were to have a large number of cases and unmitigated spread in our community and we had the masks and we properly trained people how to wear them safely, it would be a good thing for people to wear masks. That is why it is such a complicated message.

Mr BERKMAN: That makes sense. As restrictions are eased and we are seeing more public activity—for example, we are seeing larger crowds gather in stadiums, shopping centres and there has even been much concern about a few protests recently as well. In these circumstances we are seeing people use masks much more frequently. Is your advice that that is not necessary in any circumstances, even with those large gatherings, or would you suggest that there is some utility in those circumstances?

Dr Young: In Queensland today there is no need for it. It does not mean it might not change. In Queensland today I am confident we do not have cases out there that I am unaware of because it has been tested. We had those 30,000 people in Brisbane who were gathered very closely and two weeks later we have not seen cases from that. I am reasonably confident that we do not have any cases in Queensland that mean it is a risk.

Today I do not think people need to wear masks, but if people wish to wear masks, again, that is a personal choice. Hopefully they understand how to wear them. At the moment it does not matter because there are not people out there spreading virus, but, if there was virus around, the way I see a lot of people wearing them would cause them a risk due to the way they are using them.

Mr BERKMAN: You did touch on this briefly and we have seen some reporting on this, but the reports about that mass protest, the 30,000 people in Brisbane, is that there have not been any cases traced back to that. Can you confirm that is the case?

Dr Young: That is absolutely the case. We have had no cases out of that in Brisbane. In Victoria they have now had four cases in people who attended. I am not saying that they got it there or that they were infectious there necessarily, but there have been four who they know were at the march.

Mr BERKMAN: We have spoken to the minister's office and had some information provided about the cost of the Winter Beds Strategy in previous years, which is the expansion of public sector capacity by buying capacity in the private hospitals. I have been provided with figures that it cost roughly $4½ million in 2018-19 and more like $5.2 million in 2019-20, by virtue of the particularly bad flu season we had, as I understand it. Are you able to give us a sense, in average terms or generally, of the cost per bed? Perhaps another way of looking at it is: how much did we anticipate that additional capacity might have cost, based on projections here? More specifically, I am really looking to work out how much it costs us for a person who needs to be treated within the Winter Beds Strategy.

Dr Wakefield: There are a couple of points about that, but first I will pick up the thread from a previous question to answer that. Because of the excellent public health response, we are already back to 100 per cent of public hospital elective surgery, which is a fantastic result. I was talking to a colleague in the UK. They are still doing only emergency procedures. We are back up to that normal pace of elective surgery. What we have now is a backlog because of around about eight weeks of reduced activity. We have to increase our production over our normal levels of activity to be able to do that.

To answer your question about what it costs, the numbers that you have given me are not consistent with the amount of the public announcements. Our Winter Beds Strategy is usually—and I am happy to clarify this—around $15 million. I think last year we upped it to around $20 million. I can confirm the exact details. The money that is used in a winter beds strategy is used to create extra capacity in our hospital system to be able to manage not elective surgery cases; it is to manage sick people who are acutely unwell, often related to winter diseases such influenza. By and large, we use that money to buy additional space so that we have beds to put people in, so that they do not get blocked in emergency departments and so on. We do that in a number of ways. We spend that money in our current public hospitals where we expand into space that is not used traditionally. We will staff beds that may be not used all of the time. We also use the private sector and the not-for-profit sector. For example, we will buy beds in a step-down unit that might be able to take patients who are not ready for home but do not need acute care anymore. That is our Winter Beds Strategy.

Can I ask for clarification on your question in respect of COVID? I am not quite sure whether I am giving you the answer that is relevant to what you want to ask.

Mr BERKMAN: I think you have answered the question. I accept that we did not get anywhere near the demand for additional capacity that was anticipated we might have at the outset. I was trying to get a sense of the cost of the purchase of that additional capacity.

Dr Wakefield: There has been a recent announcement by the Queensland government, which has been fantastic, to allocate $250 million largely into the next financial year, but covering the last few weeks of June, to enable us to do exactly that but on a bigger scale. That is not for the medical type patients—patients who are sick with an illness and have come in—but to be able to catch up with our elective surgery activity because of those non-urgent patients. They are patients who can clinically wait for a 12-month period, by and large, but unless we do more work than we normally do that queue will stay there. We are committed to making sure that we get back to what is really excellent performance nationally in terms of our ability to treat in the high 90s per cent of patients within those clinically indicated times, not just for the urgent and semi-urgent but also for the category 3 patients. The other component of the $250 million is about outpatients. In that same queue we also have a queue of patients who were referred or may have been referred by their general practitioner. Again, we have had a couple of months where we have lost that activity. Does that help?

Mr BERKMAN: Yes.

Dr Wakefield: The only reason we are back to full capacity now, though, is because of this public health response. That is not the case in many other countries. Although the trade-off has been harsh—the social distancing measures and so on—it has allowed us to be virtually free of cases and allowed us now to get back to looking after Queenslanders, which is fantastic.

Mr O'ROURKE: Firstly, I put on the record my thanks to all the staff involved in this response. It is absolutely amazing when you look at what has happened around the world and where we are at now. Dr Wakefield, how did Queensland Health work with all the HHSs to ensure our health system was ready for a potential very large wave of cases early in the pandemic?

Dr Wakefield: In a thousand ways is probably the answer, but I can summarise a couple of key things. We are a health system and I am really proud, as others have said, of our response as a system. There is lots of history, in a sense. I have been in Queensland Health for 30 years now. The notion of one Queensland Health is still very strong in Queensland. It is often the envy of other states that are more devolved or do not have that same system response. I do not want to underestimate the impact of the underlying culture of our system on our ability to work together on a response.

At a very practical level, very early on in this, in January in fact, we started to work on planning, largely as a result of the foresight of Dr Young, to whom I listened, thankfully. We did that before some others did—this is going to be a challenge; this is going to be a problem—and well before the WHO announced it.

I shifted the traditional governance of our healthcare system into one that was more agile and more COVID focused, although it was not that we forgot about everything else. I had a group that managed business as usual. I took our generals of the healthcare system, which is my executive team in the department and all of the chief executives of the health services, into a fairly agile group. We met every single day. We met daily to manage operational issues and to oversee and work on what I would call a tactical response, or the things that we might plan to do in the next week or the next couple of weeks. That is where we worked together and that is where we butted heads if there were issues that we had to work through. I think that stood us in very good stead.

Underneath that I also had a group that supported us. It had on it representatives such as chief executives—Shaun, who is here, was part of that group—chief operating officer representatives, our consumers, our leads from the Clinical Senate et cetera, as well as a couple of my department leads. It allowed us, at the next level down, to really grapple with and work through solutions, because everything we did centrally and everything that Dr Young did as a piece of policy—and that was changing every day—had an impact on providers and vice versa.

There was no textbook for this. There were lots of bumps along the way, but I am really proud of how we managed to work as a team in a very difficult time and at a time when things were changing every day. We do not meet quite as often anymore. We are meeting twice a week now. We are just about to change our governance back to one that is probably, thankfully, more focused on what is our new normal now and how we make sure that we seize on the sorts of opportunities that COVID has brought us and on our great public health response, so that we can really harness those things for the next 12 months and not miss the opportunity.

Mr O'ROURKE: Dr Young, what are the key factors that allowed Queensland to smash the curve and to contain any outbreak once the curve was flat? For example, in Rocky we had an outbreak (inaudible) case.

Dr Young: The key factors that we need to have in place so that we can continue to manage, if we do get any cases, are firstly that we need to be able to test. That has become even more important. We can see in Victoria they are going out and testing whole communities to find where the cases are. That is the first thing. That is what we did when we went to Rockhampton when we had the case of the nurse working in the aged-care facility. It is to test.

Then it is to contact trace. We have to work and find out every single contact of anyone who tests positive and make sure that they are immediately placed into quarantine. As I have said before, that is probably one of our most important strategies now that we are aware that you can transmit the infection for up to three days before you get symptoms.

The third one is to have a really rapid response. You cannot wait to get organised. You cannot wait until it suits. When you find the very first test, it needs to be managed immediately. If you wait for a couple of days, it will not be one case that you are trying to manage; it will be a lot more. That is why you need a really rapid response, which is what we have had in Queensland. When we get each new case, we rapidly respond to that case and sort out who is there. It is through that that we can keep managing and make sure that this virus has a minimal impact on own communities.

Mr McARDLE: I also join those who have acknowledged the work undertaken by Queensland Health personnel throughout this pandemic, which is ongoing. I acknowledge the great work of Queensland citizens who have complied with the directions and other statements of Dr Young and Dr Wakefield. I acknowledge the great work they have done. Without that cooperation, it would have been a lot worse.

Dr Young, 22 January was when you received notice from the Commonwealth. Can you explain what that notice was? What were the details contained in that notice? I take it that that was the trigger for you to move forward with planning and bringing up certain bodies?

Dr Young: It had been going on for a few days at that stage. We had been having meetings at AHPPC, the Australian Health Protection Principal Committee, which is the committee made up of all of the chief health officers from all the states and the territories and the Chief Medical Officer from the Commonwealth. At that stage we had been meeting regularly because of the bushfires and our enormous concern about air quality and the impact on the various communities that had those bushfires. We met a number of times to talk through the response to the bushfires and the air quality issues and whether or not we should be providing P2 masks to those communities that had that high level of particulate matter.

I can remember the first time when Paul Kelly spoke and said, 'We might need to keep some of those P2 masks in reserve, because there is a new virus that looks like it is emerging in central China.' That was the first hint that we knew something could be happening. Then we got more information and we then had the discussion that there was a new virus, that we did not know what virus it was but at that stage it was thought to be a novel coronavirus. It took a while still after that before the genetic sequence was done and we knew what it was. That happened, so a new virus with pandemic potential—a novel coronavirus that no-one in the world would have any immunity to—would be a risk.

That is why on 22 January I declared a public health event of statewide significance. That is done under the Hospital and Health Boards Act. It enables me then to manage the resources across the state with one aim: to prepare for a significant event. At that stage I did not know how significant it would be, but I knew something was happening because of that information that we received from the Commonwealth. It happened over a number of meetings because we were already meeting very regularly because of the bushfires.

Mr McARDLE: You were concerned to make a declaration on 22 January and you then stood up the emergency centre, the SHECC, on 25 January this year; is that correct?

Dr Young: That is right. Australia had its first confirmed case on that Saturday, 25 January, so I stood up the State Health Emergency Coordination Centre on that day.

Mr McARDLE: At that point in time you had a pandemic plan that you had been modelling and remodelling and reassessing for a number of years going back 10- or 15-odd years. I do not know if that is a public document. If it is not, can you release that document to the committee?

Dr Young: Yes, it is a public document. At the national level we have had public documents that have been released. I will just check my notes. We then developed the Australian Health Sector Emergency Response Plan for Novel Coronavirus on 18 February. All of those are public documents.

Mr McARDLE: You then met in early March. I am going to page 13 of the Queensland Health briefing note. Queensland Health and the DPC met to model a scenario, I suspect, of a worst-case scenario—that is, major outbreaks across Queensland—and look at what the impact would be across a range of issues. Is that document public?

Dr Young: I think that was the cabinet exercise that was done. I do not believe that was made public.

Mr McARDLE: Is that able to be made public? I understand cabinet-in-confidence. If it is not cabinet-in-confidence, can it be made public?

CHAIR: Sorry, Deputy Chair, I think we need to clarify. If that was cabinet-in-confidence it cannot be released.

Mr McARDLE: I understand that very clearly. What I am simply asking is: if you cannot answer that question, can we put it on notice? If it turns out that it is cabinet-in-confidence I accept it cannot be released, but if it is not, is Queensland Health able to release that document? It would have been the lead body.

CHAIR: If we need to ask the question of the DPC, that might be a question for the director-general. We can write to him and confirm that. We will do that.

Mr McARDLE: Queensland Health is referred to as one of the parties involved in the conversation at page 13. If they are a party to that, are they able to advise at some point within the requisite five days whether it is a document that can be released?

CHAIR: We will place it on notice for now.

Mr McARDLE: Take it on notice; that is what I am saying.

Dr Wakefield: Can we just confirm that is the cabinet subcommittee exercise? If that is the case, I can confidently say that that will be cabinet-in-confidence. If you can confirm that is the document that you are referring to, I will certainly—

Mr McARDLE: I am going to page 13, Dr Wakefield, which states, 'In early March Queensland Health and DPC undertook modelling based scenarios.' There is nothing there to indicate it is cabinet-in-confidence or whatever. All I am simply saying is: the source appears to be a meeting between Queensland Health and DPC, and I do not know where it went. All I am simply asking is if you can take it on notice. If it is cabinet-in-confidence, I accept it cannot be released. Can you take it on notice and advise the committee if it is cabinet-in-confidence and it cannot be released? If it is not, will it be released to the committee? Is that possible?

Dr Wakefield: I will certainly take that on notice. I have the section now and we will seek to get an answer to that.

Mr McARDLE: Is does not really give detail as to where it went. Dr Young, you made some comments earlier about the worst-case scenario and outlined the number and type of people who would be infected—a mild case, hospitalised, ICU and who may die. I recall you said that the peak would occur in late April and it would continue two or three months thereafter. You mentioned that between 10,000 and 30,000 people would die in that time line. My question is: when was that figure produced?

Dr Young: That was the figure that I used early on for the modelling in terms of how we should respond as Queensland Health to prepare. It was the figure that I used in the media.

Mr McARDLE: When do you think that was? When was that figure established?

Dr Young: Very, very early on.

Mr McARDLE: Can you tell me at that point in time—

Dr Young: In February.

Mr McARDLE:—how many ventilators were available in Queensland hospitals to cope with a figure of somewhere between 10,000 and 30,000 people dying?

Dr Wakefield: Could I just confirm with the deputy chair what dates he is referring to before I answer that?

Mr McARDLE: Dr Young confirmed that the figures she gave were very early on in relation to the pandemic. I am simply relating my comment back to that very early date and how many ventilators would have been available at that point in time across Queensland to deal with that number of deaths.

Dr Wakefield: I can answer that.

Mr McARDLE: It can be taken on notice, perhaps.

Dr Wakefield: I can answer that. There are two points in response to that. The first one is that, based on the modelling and the scenarios that we had considered very early on, Dr Young had advised that we needed to double our intensive care unit capacity. As a consequence of that, a lot of work was done to understand the answer to two questions (1) what was our intensive care capacity across the public and private sector, which was around about 400 intensive care beds across the public and private sector; and (2) what did we need to expand that to and then, of course, how quickly could we get there and what did we need to do?

The answer to the second question was that we needed to get to 800 intensive care beds or ventilated bed capacity, obviously, from a base of 400 across the public and private sector. I am incredibly impressed—was and am—about how we mobilised using our statewide intensive care network. I think this goes back to what I said earlier. As a system, Queenslanders can be very confident that we do not just break it up into health services; we have system based groups—an intensive care network that has been there for years that helps us horizontally manage this. Working across the public and the private sector, they were able to very quickly shift to a capacity of 800.

That does not mean to say that we had 400 empty beds from day dot, but we knew that with the ventilated capacity that we had, but also with ventilator alternatives like anaesthetic machines, for example, that can function as a ventilator and the beds and, as I said, the nursing staff and medical staff where we did a lot of training to support that, we were rapidly able to move to stand up 800 intensive care unit beds. We never had to do that, but we were absolutely ready to do that. In fact, at a point in time—and I would have to confirm exactly when that was—we started to shift to, 'How can we go beyond that?' because, again, some of the modelling suggested that, depending on where we were with the public health response, we may have had to have more than double our ICU capacity. That was work that was done, so we had 800 and we have now the capacity for 800 ventilated beds.

The question around how many ventilators we had and what we needed to order, going back to earlier this year we ordered a total of 1,432 ventilators. As of now, 956 of those ventilators are in our hands; 476 remain outstanding because—again, just like PPE—the world market for ventilators became very hot and so we still have back orders. As it happens, because of the great work of the public health response and the community we do not need those today, but we are not out of this yet. I think, certainly as director-general, my job is to make sure that we have reasonable readiness for the scenarios that we may face.

Mr McARDLE: Am I right in assuming that on 25 January this year we had 400 ventilators in this state? If we had 400 ICU beds, were there then 400 ventilators?

Dr Wakefield: At that date, which would have been fairly well baseline in the context of COVID as an emerging issue, our base capacity across public and private sectors was around 400 beds, yes.

Mr McARDLE: They would have been predominantly in the south-east corner: Metro North, Metro South and the Gold Coast predominantly, given the population base?

Dr Wakefield: Correct.

Mr McARDLE: I think you said now we have 800 ICU beds; therefore, we have, I think you said, 1,432 ventilators. How are they dispersed across the state?

Dr Wakefield: Perhaps if I just go back. As a matter of fact, in operation we had baseline around 400 intensive care beds. Those beds are there with ventilators and staff, and they get used by and large on a day-to-day basis. Our plan was to enable us to ramp up to 800. That required us to commission other parts of the hospital, bring in equipment and so on to be ready.

I am wondering at this stage, just by way of giving an example, if it would be worth calling perhaps one of the chief executives to maybe give a sense of how that happened on the ground. Would that help, Deputy Chair?

Mr McARDLE: My question was really: how are they dispersed across the state at the moment? That would be an essential Queensland Health determination.

Dr Wakefield: I can get you the numbers of those. In terms of where, there are about 600 in South-East Queensland, but obviously the capacity to expand intensive care really depends upon the initial intensive care capacity to start with. It is partly the beds and infrastructure, but actually much more important is the expertise and the staffing that goes with it.

Mr McARDLE: Dr Wakefield, I would appreciate it if you would take that on notice and provide that to the committee as to where they are dispersed—just the HHSs, not the individual hospitals.

Dr Wakefield: The breakdown of the 800—where they are? Is that the question?

Mr McARDLE: Yes, and I need the number of HHSs, not the hospitals within the HHSs.

Dr Wakefield: I am happy to take that on notice and provide it to the committee.

Mr McARDLE: Chair, I am aware of the time. I do have questions for Commissioner Bowles, but I also have a time limitation myself in relation to how much longer I can attend this hearing given our own timetable. Is it appropriate to consider reconvening at another date because there are important questions regarding the paramedics I wish to ask and I also have more questions of Queensland Health?

CHAIR: Future hearings will have to be resolved in a private meeting. If you want another five or 10 minutes, we can probably accommodate that.

Mr McARDLE: I would like another five minutes. I do apologise. The time line that we set is impacting upon another matter that I have to deal with. Dr Young, you mentioned that between one and three per cent—that is, between 10,000 and 30,000 Queenslanders—may pass away in the first wave in the worst-case scenario. Not all of those patients would need ventilation at the same time. I accept that as common sense. There are also other patients who would need ventilation for other purposes, so the 400 ICU ventilation beds would reduce by a certain proportion. My concern is: if the figures of 10,000 to 30,000 came to be reality, we would be facing some major questions in relation to how we allocate the ICU beds. Would that be correct?

Dr Young: No. I felt that by doubling the ICU capacity and also putting in place other strategies such as decreasing elective surgery we could create enough room to be able to treat those people. We did all of the modelling and we based it on the following: that 100 per cent of people up to the age of 80 who needed an ICU bed for their clinical condition would get it and 50 per cent of those people over age 80 would get an ICU bed, because we know that people over age 80 are less likely to go into ICU because it is not appropriate for their clinical care. If we looked at the percentage of people over the age of 80 who become unwell and would end up in ICU, it is much less than 50 per cent. We did the modelling looking at providing ICU care to every person and more than we thought would access it or need it for their clinical condition. For instance, of the four people who have died here in Queensland from COVID-19, only one of those had ICU. Decisions are made by individuals about what type of care is appropriate for them. I think that with that planning that was done we would have been able to offer ICU care to every single person who would have benefited from that ICU care.

Mr McARDLE: I thank you for that. Let us take the worst-case scenario a step further. Just say we had a major outbreak in Cairns or Mount Isa, a more remote location, and there were a significant number of people who needed ventilation and at the same time there was a major outbreak in the south-east corner. Are you saying to the committee that, even though there would not be sufficient beds normally in Cairns to deal with the major outbreak, those patients would be flown to Brisbane for ICU or—

CHAIR: I think that—

Mr McARDLE: This is the plan, Chair, I referred to—the modelling for the worst-case scenario. How would a scenario of that nature be dealt with?

CHAIR: Can I just point out that I recall, Deputy Chair, investment in extra aeromedical jets. That would be something for Retrieval Services Queensland, to allocate beds close by. Dr Young?

Dr Young: There are a few things here. This is not flu; this is coronavirus. One of the biggest differences is that people do not suddenly get ill with it. They have a period where they gradually get more ill and then they get significantly ill and need intensive care. We know that the vast majority of people get significantly ill at day 5 or 6, and that is when they need intensive care. We have plans in place for our discrete First Nation communities, for instance, that anyone who develops the infection who lives in one of those communities would be immediately aeromedically evacuated to a centre to be managed. Similarly, anyone in a place like Mount Isa or a place where there are fewer intensive care beds would be aeromedically evacuated to Brisbane.

Very early on we sorted out two additional jets to be based in Townsville and two additional jets to be based in Brisbane. Those have been in place since the start. I recently reduced that—because we have not needed them—to one in Townsville and one in Brisbane, but we could rapidly put those other two back into place if they were required. That was part of our planning. It has always been in place that we would move people around if there were not the resources locally, to ensure that every single Queenslander who needed access to intensive care would be able to get it.

Mr McARDLE: I want to ask Ms Phillips a question regarding PPE and then I will stop at that point.

CHAIR: We have about four minutes left.

Mr McARDLE: Ms Phillips, thank you for being here today. You gave testimony that as at today's date we have 99 days of PPE equipment in stock in the critical list—not all but most of them. Do you know how many days we had in stock back on 22 January 2020? What was our stockpile back then?

Ms Phillips: Apologies, if I can just correct you: what I said was 90 days of stock, not 99 days. I would like 99 but I have to make do with 90.

Mr McARDLE: I will blame the technology.

Ms Phillips: I do not have those figures to hand to tell you exactly, but I could attempt to get those figures in terms of the stock, remembering of course that I am working from a distribution centre basis. This is stock that is held at the distribution centre, not stock that is held at HHSs. That is a separate set of volume. I would say that stock—and I have learnt this over the last week while—is very fluid, so it is always moving. The stock levels change daily and they can go up and down.

In terms of breadth for you, perhaps it would be useful for me to give an example of what we were distributing from the distribution centres in what I would class as pre COVID—that is, before we had the event take over. We were distributing an average of 5.4 million items. That is both PPE and business-as-usual items that were distributed across the state to HHSs. When we moved into the COVID experience, we averaged about 8.6 million items that were distributed statewide. As of last week, beginning 15 June, we were at 9.7 million items that were distributed throughout the distribution centres. That is to give you some idea of the scope of the items that are moving daily across the state.

Mr McARDLE: Ms Phillips, you indicated there was a challenging environment when COVID-19 hit the world. China was scrambling to get equipment and other countries were as well. You mentioned that new providers entered the market. Did we source from overseas and from interstate as well as existing suppliers for PPE?

Ms Phillips: I am sorry. Did we source?

Mr McARDLE: You mentioned new providers. Did we source PPE requirements from interstate and overseas as well as from existing suppliers?

Ms Phillips: Yes, we did. In the initial stages of the experience from COVID, what we found was we had a lot of direct inquiries from vendors who were both from overseas or, if you like, middle people who transported supplies to us. We also had some coming from other states and some from our state. We needed to do due diligence over them to see whether or not we would continue to do procurement with those, but we had a variety coming forward for those. From memory, I think we probably had about 800 inquiries in the first couple of weeks that just came in unsolicited to us, but I can check that figure and get a correct figure for you, if you like.

Mr McARDLE: Would you mind? I would appreciate that.

Ms Phillips: I will bring that back to the committee.

CHAIR: I thank all members for their contributions today. I also thank all of the staff, particularly Dr Wakefield and Dr Jeannette Young, for being here today. We also ask that responses to questions taken on notice be returned by Monday, 29 June. We look forward to catching up with the department representatives again in the future. Thank you very much for your time today. It has been a huge benefit to the committee tasked with reviewing the COVID response. Again, thanks to all of you for the enormous efforts that you have put into keeping Queenslanders safe.

Dr Wakefield: Thank you, Chair, Deputy Chair and committee, and thank you to all my colleagues.

CHAIR: I now declare this briefing adjourned.

The committee adjourned at 12.56 pm.