REPORT ON PROCEEDINGS BEFORE

STANDING COMMITTEE ON LAW AND JUSTICE

MANDATORY DISEASE TESTING BILL 2020

CORRECTED

At Macquarie Room, Parliament House, Sydney on Thursday, 11 February 2021

The Committee met at 9:45 am

PRESENT

The Hon. Wes Fang (Chair)

The Hon. Catherine Cusack
The Hon. Anthony D'Adam
The Hon. Greg Donnelly (Deputy Chair)
The Hon. Scott Farlow
The Hon. Trevor Khan
The Hon. Shayne Mallard
The Hon. Rod Roberts
Mr David Shoebridge

The CHAIR: Welcome to first hearing of Standing Committee on Law and Justice Inquiry into the Mandatory Disease Testing Bill 2020. The inquiry is examining the provisions of this bill, which seeks to establish a mandatory testing scheme for specific bloodborne diseases in circumstances where police, emergency services and health workers have been exposed to possible risk of transmission by a deliberate act of a third party. Before I commence, I acknowledge the Gadigal people who are the traditional custodians of this land. I also pay respect to the Elders past, present and emerging of the Eora nation and extend that respect to other Aboriginal people present. Today we will be hearing from a number of stakeholders including unions representing affected workers, public health experts, academics and advocates, organisations representing potentially affected communities, and members of the legal profession. While we have many witnesses with us in person some will be appearing via videoconference today. I thank everyone for making the time to give evidence to this important inquiry.

Before we commence I will make some brief comments about the procedures for today's hearing. Today's hearing is being broadcast live via the Parliament's website. A transcript of today's hearing will be placed on the Committee's website when it becomes available. In accordance with the broadcast guidelines, I remind media representatives that they must take responsibility for what they publish about the Committee's proceedings. While parliamentary privilege applies to witnesses giving evidence today it does not apply to what witnesses may say outside of their evidence at this hearing. Therefore, I urge witnesses to be careful about the comments they may make to the media or others after they complete their evidence. Committee hearings are not intended to provide a forum for people to make adverse reflections about others under the protection of parliamentary privilege. In that regard it is important that witnesses focus on the issues raised by the inquiry terms of reference and avoid naming individuals unnecessarily.

All witnesses have a right to procedural fairness according to the procedural fairness resolution adopted by the House in 2018. If witnesses are unable to answer a question today and want more time to respond they can take a question on notice. Written answers to questions on notice are to be provided within 14 days. If witnesses wish to hand up documents they should do so through the Committee staff. In terms of audibility for today's hearing I remind both Committee members and witnesses to speak into the microphone. As we have a number of witnesses in person and via videoconference it may be helpful to identify who the question is directed to and who is speaking. For those with hearing difficulties who are present in the room today, please note that the room is fitted with induction loops compatible with hearing aid systems that have telecoil receivers. Finally, I ask that everyone turn their mobile phones to silent for the duration of the hearing.

NICOLE JESS, Senior Vice President, Chair, Prison Officers Vocational Branch, Public Service Association of NSW, affirmed and examined

STEWART LITTLE, General Secretary, Public Service Association of NSW, affirmed and examined

TONY BEAR, Manager, Strategy and Relationships, Police Association of NSW, sworn and examined

PATRICK GOOLEY, Secretary, Police Association of NSW, sworn and examined

The CHAIR: I now welcome our first witnesses. Would anybody like to start by making a short opening statement? I ask that you keep it to no more than a couple of minutes.

Mr GOOLEY: Thank you, Mr Chair. I, too, acknowledge the traditional owners of the land, the Gadigal people of the Eora nation, and I pay my respects to their Elders past, present and emerging. Thank you for the opportunity for the Police Association of NSW to appear at this inquiry. We represent over 17,000 police officers across the State of New South Wales who for 24 hours a day, seven days a week face dangers, risks and challenges. Some are rare, some are remote and some are common, but all take their toll on our members. As the Committee goes about the task of examining this bill we ask that you do it through a lens of work health and safety, through the lens of the mental health of a first responder and in view of the challenges that our members face every day.

Between Mr Bear and I, we have over 50 years of operational policing experience but, moreover, we have experience of supervising and supporting our members that have been exposed to bodily fluids and the trials and tribulations that follow such an exposure. We have both had the opportunity to read all of the submissions that are published on the Committee's website and the concerns raised in those submissions, and we do not dismiss them. We do, however, believe that this bill fairly deals with those concerns and is a measured response to a real risk that our members face, however remote. We believe it balances the rights of the frontline worker against the rights of the miscreant who has deliberately applied a bodily fluid to an emergency service worker, often in violent circumstances. The application of those bodily fluids to a police officer can only be in response to an officer doing their job, in retribution for doing it or to discourage them from discharging their duty to protect the community

We saw four key themes emerge from the submissions and I would like to briefly address those; we would then be happy to take your questions about those themes or any other issue. The first theme is the lack of utility in taking a blood test. The NSW Health department guidelines call for the taking of a blood test during an occupational exposure. It provides an important piece of the puzzle in determining the treatment, and any information that benefits the medical practitioner and the worker who has been exposed to the bodily fluid is an important piece of that puzzle.

There is a theme of infringement upon bodily autonomy. Today across New South Wales dozens of people, without any assessment of their liability, will provide a sample of their blood against their will. Some will be under arrest by a police officer and some may face the reasonable use of force to attain that blood sample. In all cases a doctor refusing will also face a criminal sanction. To evaluate the rights of a miscreant who has decided to apply a bodily fluid as higher than the rights of a police officer or any motorist in New South Wales who is involved in an injury collision would be a perverse outcome.

We also note the theme of increased stigma for people who are living with bloodborne diseases. We say this bill does not do anything of the sort. This bill is a measured response to a risk faced by our members. It does nothing to stigmatise those who may be living with bloodborne viruses. In society it is not acceptable for someone to deliberately apply a bodily fluid. Again, we say to elevate their rights above the rights of a worker who has been exposed would be a perverse outcome.

Lastly, I address the theme of the effect on marginalised communities. This is a ruse that is often thrown up in powers that police may exercise. Without debating the legitimacy of those concerns in other bills, we simply say there is no evidence that members of marginalised communities have a higher propensity or in any way are walking around the streets of New South Wales deliberately applying bodily fluids to emergency service workers. To say so is only to further marginalise those communities. It is also totally inconsistent with my lived experience as an operational police officer for over 20 years who has had a number of blood exposures.

We believe the bill provides adequate safeguards: a guided step-by-step process that commences with consultation with a qualified medical practitioner; that rigorously examines the circumstances of the exposure and is part of the assessment of whether to grant an order that involves advice from the Chief Health Officer; and adequate safeguards in terms of appeals and reviews. This is all oversighted by the NSW Ombudsman. At its core, we say this bill provides better certainty in treatment and better information for our members. It is always open throughout the conduct of this bill for a source person to voluntarily provide a sample and then be covered by the

safeguards the bill provides in regards to their health information. We believe this is a measured response and an appropriate bill, and that it should be carried through in its current form. Thank you.

Mr LITTLE: I would also like to acknowledge the Gadigal people of the Eora nation and other First Nations people who are here with us today. I would like to extend my thanks to this special Committee for hearing this matter today. The Public Service Association of NSW [PSA] welcomes the opportunity to advocate in favour of these laws, which we believe will greatly assist our members. Our members who work in Corrective Services NSW and Youth Justice NSW are often assaulted. That is a daily reality. In addition to this, they may also face the psychological stress and uncertainty of wondering whether they have been infected with a disease. Our members have a job where they cannot choose to walk away from danger and must walk towards it. The behaviour of inmates and detainees is such that we are seeing more staff assaulted each year. This law addresses a fundamental safety issue. Inmates in New South Wales are at high risk due to a range of comorbidities, including fatal bloodborne diseases such as hepatitis C, with 22 per cent of the prison population, which is 20 to 30 per cent more prevalent than outside of a correctional setting.

Due to a number of factors, including the effects of the COVID-19 pandemic, there has been a marked increase in serious assaults and incidents in jails. As highlighted in our submission, Corrective Services has seen a huge increase in staff assaults over the past five years. Corrective Services has also seen the use-of-force incidents double in the last five years. In Youth Justice, despite a reduction in detainees in the system, there has also been a marked increase in assaults. In Corrective Services NSW, for the period 1 January 2020 to 31 October 2020, there were 135 incidents where correctional officers were exposed to bodily fluids. Spitting constitutes the most common form of assault on staff, followed by being punched.

Further, in the past three years, there were 448 incidents recorded of officers being exposed to bodily fluids, including saliva, blood, semen, faeces and urine, and these figures include a total of 32 needlestick injuries. In Youth Justice in 2020—the following Youth Justice data may be a conservative estimate—for the period of 1 January 2020 to 31 December 2020, we are advised of 67 incidents, involving 99 detainees, that were recorded involving spitting by a detainee at and/or in the direction of staff and others. One detainee, who cannot be named, has some 40 incidents recorded, over two detention centres, of assaulting staff involving spitting. That is one detainee.

In the current environment, there is an international pandemic spread by saliva aerosol droplets; a prison population with incidence of hepatitis C at levels of over one in five; and inmates/detainees using their bodily fluids as a mechanism to assault staff. Our first three recommendations are procedural recommendations to assist assaulted officers to gain access to the testing more efficiently, and to allow for better recording and accountability of these measures in Youth Justice. Whilst we have also recommended a review of personal protective equipment [PPE] as part of our submission, this is only part of the solution. It is vitally important that the disease definition be extended to COVID-19, as outlined in our recommendation. These laws will not be unique to New South Wales and there are similar laws in several other jurisdictions in Australia. This is an opportunity for New South Wales to address the issue of mandatory testing. New South Wales needs a system that can assist workers, who already have a very difficult and challenging job, to reduce their anxiety and stress without the worry that they will be potentially suffering a deteriorating disease, which they could unknowingly spread to their family and friends.

The CHAIR: Does anybody else have an opening statement they wish to read? If not, I will go to questions.

The Hon. ANTHONY D'ADAM: I might just start by declaring that I worked for the Public Service Association of NSW for 17 years. I just wanted to place that on the record.

Mr DAVID SHOEBRIDGE: If we are in a disclosing mood, I am a member of the PSA.

The Hon. ROD ROBERTS: I do not know if I need to disclose it, but everybody knows I did 20 years in the New South Wales police.

The CHAIR: I thank you for those disclosures, gentlemen. We will open the questioning.

The Hon. TREVOR KHAN: I will make two disclosures for a start. One, some years ago, obviously with a client who was unhappy with me in the cells, he spat in my face. So I have some considerable sympathy. I actually subsequently acted for him at trial and got him off.

Mr BEAR: It is because you are so good.

The Hon. TREVOR KHAN: That was partly the answer. And country juries are a bit perverse, so we will weigh up. The other is, my son was the subject of a needlestick injury in his work so, again, I understand, in terms of dealing with my son, the trauma that both speakers have spoken of. I have got sympathy with some of the matters. I just wanted to ask some questions with regard to the bill in a practical sense. If I go to essentially

the operative clause—clause 7 of the bill. The criteria in subclause (1) (b)—let us go past execution of a duty because we will assume that is a given. If we go to a deliberate act of a third party, I am interested in where you see the limits of a deliberate act. If I talk in terms of Corrective Services, we have got a prisoner who has secreted in their cell a syringe, which obviously they have been using for the purposes of injection, and in the course of the execution of a search of that cell, a needlestick injury occurs to an officer. Is that a deliberate act of the holding of that syringe in the cell?

Mr DAVID SHOEBRIDGE: Or the hiding of it in a way that could surprise somebody.

The Hon. TREVOR KHAN: The hiding, yes. Is that a deliberate act of a third party?

Ms JESS: I would say that it is a deliberate act of not following legislation. That is a form of contraband, they are not allowed to have it, they know that, so it is a deliberate act to hide it purposefully, and also knowing the risk to staff and other inmates, because they could be sharing a cell with another inmate as well. The risk that it would pose is not just to officers; it would also pose a risk to another inmate.

Mr LITTLE: It may depend on the circumstances, of course. It is difficult just to say because you would have to look at the circumstances surrounding the incident.

Ms JESS: We have had situations where inmates have purposefully hidden cut-down syringes with the top off in locations that are sticking out of areas, so they are purposefully placed there. The majority of needlestick injuries would have the needle capped and would be hidden behind toilets or something like that, or in a light. But sometimes we have had situations where the needle has been exposed on purpose and in a place where they know that you would be going to search, like under a mattress or under a pillow.

The Hon. TREVOR KHAN: Whether it is justified or not, the reason I ask is the examples given in the opening statements are generally in the nature of assaults and what we are now exploring is a much wider range of circumstances. Let me go to the next one, and I will direct this to the police representatives. What are the circumstances—the very common circumstance, I think—of where officers come into contact with, I will call them an accused at this stage, who has either self-harmed or alternatively is injured and therefore bleeding. Again, what happens is the police officers come into contact with the blood, not as a result of a direct smearing or the like, but rather by the simple act of arrest and perhaps a degree of resistance by the accused. Is that sufficient to constitute a deliberate action of the third party—that is, the resistance?

Mr BEAR: With the bill—and we have been on record from August 2017—we initially said that would be through our evidence and our initial opinion, but given that the stakeholders—the Department of Justice, the department of Health and so forth—have worked through this bill over those four years, we have come to the understanding that, as far as we are concerned for our members, it has to be a clear, deliberate act. So subsequently, no, that is not, in our view, a deliberate act, Mr Khan.

All the circumstances within each type of incident have to be taken into account on each individual time. It is was a very broad statement that you made in regard to, "He had some blood and he's thrashing around or he's being arrested." There are safeguards within the bill that say providing false evidence on either side is wrong and can be assessed within the bill. What I am trying to say is, if the person was just being arrested and the police officer had a cut on their hand, and whilst they were putting the handcuffs on that person the blood was transmitted, no, that is not a deliberate act. If the person within that was fighting and floating around and flushed their cut towards the police officer and that subsequently went into their eye, I would say that is a deliberate act. So it is subjective to each one of those—

The Hon. TREVOR KHAN: Let me just say you have got me on board on that one. It is the more indirect ones that perhaps interest me in my line of questioning.

Mr BEAR: Unless it is a deliberate act, we do not believe that we have the power to take—

The Hon. TREVOR KHAN: Can I ask one final question? Then I will be finished. It partly arises out of your last answer, Mr Bear. If, in fact, blood comes into contact—skin contact; we are not going to worry about clothing—with an officer, but not on their face and not on a cut, does this bill allow, as opposed to whether somebody exercises their discretion, an accused to be the subject of a mandatory test in those circumstances?

Mr BEAR: The bill clearly outlines that there must be a passing on of a bodily fluid.

Mr DAVID SHOEBRIDGE: It just says "contact".

Mr BEAR: No, it has to—

Mr DAVID SHOEBRIDGE: "Come into contact with".

Mr GOOLEY: I can answer that. Obviously the first step is for the person exposed to go and seek medical advice. That medical advice then has to be provided. The person then has to make a decision to apply for an order or not. Should they apply for an order, the officer making the determination, a senior officer, has to take into account the circumstances of the transmission, the advice of the health professional and the standing advice that will be provided under the bill, if it goes through in its current form, by the Chief Medical Officer. So the circumstances would have to arise where the senior officer believed the risk of transmission justified the making of the order. These are senior officers who make these determinations in terms of forensic procedure orders. The definition of a senior officer immediately encompasses people who make decisions based on this evidence on a regular basis in other settings.

Mr DAVID SHOEBRIDGE: Senior officer for police includes an inspector.

Mr GOOLEY: That is correct.

Mr DAVID SHOEBRIDGE: So it is not a judicial officer. Do you believe that if an order has been made against a person by an inspector, there should be a right of appeal or review of that?

Mr GOOLEY: Of the order?

Mr DAVID SHOEBRIDGE: Yes.

Mr GOOLEY: I believe the bill strikes the correct balance between the ability to obtain the blood sample when required and allow an appeal for a process that then may prevent, if upheld, the provision of the result of the test in the very strict circumstances that it does provide for it. I think it is an adequate safeguard.

Mr DAVID SHOEBRIDGE: If we could go back to the concept of "deliberate," I think the issue that we are avoiding confronting is whether or not it is intentional. Ms Jess seemed to be suggesting that there were circumstances where needles are placed with the intent to cause harm. I think if I understood your proposition, Mr Bear, you were suggesting that if the resistance was done in such a way that there was an intention to spread blood or fluid into someone's eye or a cut, then it would fall within the scope of your concept of a "deliberate act". Is it your understanding that the term "deliberate" requires an intentional transmission of the fluid? I will start with you, Mr Gooley.

Mr GOOLEY: Thanks, Mr Shoebridge. I think it is impossible for any bill to contemplate every circumstance, but I believe the language of the bill allows for a range of circumstances that can and, on many occasions, will arise.

Mr DAVID SHOEBRIDGE: But I am asking you about this concept of "intention". Do you believe it requires the intention to transmit the fluid?

Mr GOOLEY: I believe "deliberate" encompasses intention. I think it is a wider term.

Mr DAVID SHOEBRIDGE: So the long and the short of it, Mr Gooley, is that if it is intentional, it is deliberate, but it could be deliberate but not intentional.

Mr GOOLEY: Again, if only by illustration, as Mr Bear said, the deliberate and intentional flicking of blood into a police officer's eye is clearly intentional.

The Hon. TREVOR KHAN: Got me there.

Mr GOOLEY: Flicking the blood in the direction of the police officer is a deliberate act that caused the blood to go on there. So taking its ordinary meaning, "deliberate" is a deliberate action that applies—

Mr DAVID SHOEBRIDGE: But it does not have to be with the intent of transmitting the fluid. You accept that there are circumstances where it does not have to be with the intent of transmitting the fluid.

Mr BEAR: Of course not. When I was giving mouth-to-mouth in 1994 to a person who had a heart attack at Leichardt Oval and he had spewed up in my mouth and there was blood in my mouth, that was not intentional by that person.

The Hon. TREVOR KHAN: But that might be precisely the circumstance that is not covered by this bill, which really warrants protection.

Mr BEAR: That is right. It is not covered by the bill.

The Hon. CATHERINE CUSACK: But I am trying to understand that specific issue. Why would it not—

The CHAIR: Order! Mr Shoebridge has got a line of questioning, which he will need to finish.

Mr DAVID SHOEBRIDGE: I perfectly understand how you want to capture the intentional transmission. I am just interested in the circumstances where it is not intentional but there is a deliberate act. I think you all agree—and correct me if I am wrong—that there is an unknown, real set of circumstances where there may not be the intention to transmit the fluid but it is a deliberate action, and you want that caught by this bill. Is that right, Mr Little?

Mr LITTLE: Yes, that is right. If you want to use the example, Mr Shoebridge, that Ms Jess gave before of inmates secreting needles—it is a case that they do secrete needles. Unfortunately, depending on the jail and the circumstances, they place them in such a way, intentionally and deliberately, to cause injury. They do do that.

Mr DAVID SHOEBRIDGE: But there were two categories—

Mr LITTLE: Other times they will hide them with the intention that they cannot be found, obviously.

Mr DAVID SHOEBRIDGE: But you want the bill to capture that second set as well. That is your understanding, is it not?

Ms JESS: I think that the decision-maker should be able to take in all relevant facts and ensure that the staff member is supported in making sure that if there has not been—for the sake of the syringes, if they determine that the syringe was actually placed on purpose with blood still in it, or with something else, then this affects the outcome. Can I just add—

Mr DAVID SHOEBRIDGE: But Ms Jess, you said a great deal more than that.

The CHAIR: Order! Mr Shoebridge, allow Ms Jess to continue.

Mr DAVID SHOEBRIDGE: You said "hidden behind the toilet".

Ms JESS: They can be hidden behind the toilet, but they can also be purposefully hidden with the cap off for us to find them and to be stuck by a syringe. Can I just add in the example that was given in regard to someone that may self-harm. We on numerous occasions have to enter with inmates that have self-harmed, with large amounts of blood in the cell. When that happens, not necessarily is the inmate happy that we are entering that cell, and we have to use force on that inmate. In that time, we will use force, we will get injuries, we will cut our hands, we will cut our legs. It may not be the intention of that inmate, at that time, to pass intentionally any blood. But in the action of helping that inmate and placing that inmate into another safe environment, we may be injured and have to get contact with that blood.

Mr DAVID SHOEBRIDGE: But that action of self-harm, someone slitting their wrists, for example, in a cell would be a deliberate act in your mind that would be covered by this bill.

Ms JESS: Yes.

Mr DAVID SHOEBRIDGE: There is just one other issue I wanted to address. How would you envisage police using reasonable force to hold somebody down, restrain somebody while a medical practitioner comes in and takes an involuntary blood sample? Have your officers done that before in any circumstances, Mr Gooley, Mr Bear?

Mr GOOLEY: I have not personally experienced it. The only time restraining a patient for a medical procedure has been the injection of medication by a medical practitioner in an emergency circumstance. I do note that, if you were to drive out the front of Parliament, park at a light here, and a cyclist ran up the back of you and potentially was going to die in the next 30 days, the legislation provides that you must provide a sample of blood whilst under arrest by a police officer and it provides for a use of force. Clearly, the medical practitioner will have an obligation to take the blood. There will be a point, as there is in all blood samples that are taken now, where the risk outweighs—and the person may then be liable for the offence of not complying with the Act.

The Hon. TREVOR KHAN: And that gets them for a high-range prescribed concentration of alcohol [PCA] offence. So it is six of one, half a dozen of the other, is it not?

Mr GOOLEY: No. In the case of a fatal accident, it is far more serious.

Mr DAVID SHOEBRIDGE: In the case of a fatal accident—

Mr GOOLEY: Or a potentially fatal accident, where you are no more than a driver stopped at a red light and there is no assessment of your involvement in the collision, you are merely involved in the collision. So what I say is that—

Mr DAVID SHOEBRIDGE: But I am asking you about how it would work in practice, Mr Gooley.

The Hon. SCOTT FARLOW: Point of order: Can we let Mr Gooley finish his response?

The CHAIR: I am going to uphold the point of order from Mr Farlow. Mr Gooley, you have the opportunity to finish. Then Mr Shoebridge can ask a further question. However, I just note we only have about 20 minutes left and I know Mr D'Adam, Ms Cusack and Mr Farlow have questions.

Mr GOOLEY: In the circumstance envisaged by this Act, if a medical practitioner said, "It's not safe and I'm not doing it", or there is resistance, or in the police officer's mind he became too dangerous to restrain and they had to release the prisoner due to a whole range of factors that police are trained in, then that would be the end of the scenario. Obviously, I would envisage that that third person would then be subject to sanction under the Act.

Mr DAVID SHOEBRIDGE: I do not know whether that answered my question about how it would work in practice. What about in a prison scenario? You mentioned a juvenile who had had 40 occasions of spitting.

Mr LITTLE: That is right.

Mr DAVID SHOEBRIDGE: Would the intention be that, if that juvenile refused, there would be 40 occasions where the juvenile would be restrained and tested?

Mr LITTLE: I am not sure how that would manifest itself. But I can tell you that the one individual, who is very well known to us, has deliberately walked up, chewed the inside of his cheek, spat blood in the face of officers, unprovoked. The consequence of that is that I have had 15 members on extended workers compensation. But the same individual, who is now in the adult system—that is right. He has across two centres wreaked mayhem in that centre, caused huge problems. Obviously, the intention is not that our members will be involved in that. What we have asked for is that the police then attend, charge that person rightfully with assault and that they are the ones then that oversee the mandatory testing.

Mr DAVID SHOEBRIDGE: Strap the child down and remove the blood.

Mr LITTLE: Well, I am not sure how it would manifest itself.

The CHAIR: Order! That is inappropriate.

Mr DAVID SHOEBRIDGE: That is what I am trying to ask—how will it work in practice—and nobody answered me.

Mr BEAR: That is ridiculous.

Mr DAVID SHOEBRIDGE: Well, how would it work?

The CHAIR: Order! Mr D'Adam has the call.

The Hon. TREVOR KHAN: That subject with the child—

Mr BEAR: It is a vulnerable person under the Act.

Mr DAVID SHOEBRIDGE: Fifteen, or 16?

Mr BEAR: David Shoebridge is just taking it to the nth degree in his biased attitude towards police.

Mr DAVID SHOEBRIDGE: I asked how it worked in practice and nobody answered.

The CHAIR: Order! We are going to have some semblance of order. Mr Shoebridge, those comments were inappropriate but, Mr Bear, also I ask you just to—

Mr BEAR: Sorry, Chair.

The CHAIR: I appreciate that. Thank you. Mr D'Adam, you have the call to ask some questions.

The Hon. ANTHONY D'ADAM: Thank you for your submissions and your appearance today. This is obviously a sensitive issue, the use of compulsion for testing. As a public policymaker, my inclination is to be quite restrained, to try to be limited in the extent to which we might traverse on a particular right or established civil liberty. With that said, it seems that the purpose of both parties here today in pursuing this bill is really focused on the weaponising of bodily fluids. On that basis it seems that, if we apply that principle that I just outlined, we should be very much focused on limiting the extent to which the compulsion is used to the circumstances where bodily fluids are weaponised. Earlier we had that discussion around being deliberate and whether it is perhaps malicious intent. That might be a way of narrowing the application to those circumstances where bodily fluids are really used with some form of malicious intent behind it. Can I ask both parties about your view of a proposition that the bill perhaps be narrowed in that respect and what reservations you might have if that approach was taken.

Mr GOOLEY: The reason the Police Association supports this bill in its current form is we believe a correct balance has been struck. It is not a novel situation in New South Wales where a person can be compelled on threat of criminal sanction and potentially with use of force to have their blood taken. You are right: This is about when people do weaponise the application of a bodily fluid. It is a retribution or it is to discourage you from performing your functions. To look at things like malicious intent—the proper function of this bill requires the timely taking of the sample, we believe, in an appropriate period. You are elevating a senior officer in one of the agencies to a judicial function. Effectively, they are determining criminal matters such as malicious intent. This is not about creating an offence. We honestly hope that, if this bill passes, every person that may be subject to the bill participates and does not create the offence, because the information is important to our members. To look at things like malicious intent—I think we are going down a path of this criminal law application of it, as opposed to what I said earlier about this being about work health and safety, about the mental health of the first responder that is out there doing their job.

I understand earlier Mr Shoebridge was making the point about the difference between intent and deliberate. I think we cannot cater for every circumstance in a bill, but this strikes a balance that allows it to at least be considered with proper advice from a medical practitioner, the circumstances, the mere application of the officer—the officer that is requesting it has to make an application and form a view that they would benefit from the result of the test—then the advice from the Chief Health Officer. To narrow it further would, I believe, render the bill far less useful and narrow it to a scope where we are almost creating a separate offence of applying a bodily fluid. This is not about retribution; this is not about further criminalising abhorrent behaviour. This is about improving our members' mental health, just taking one brick out of the brick wall that is mental health for a police officer, and a sensible, reasoned approach with proper medical advice. If we narrow it too far, we put that whole process at risk.

Mr BEAR: Can I just say, Mr D'Adam, it does not matter whether you use the word "intentional" or the way you talk about it. Again all you are doing is changing wording. It would be subjective to that as well. The intention through the committees and the four years of backwards and forwards was to make sure that a law-abiding citizen, whether through an accident or an unintentional exchange of fluid, is not subjected to any further interaction with police. We see—and you will get it from Health—that they go down to their people or the people with a needlestick injury in the 2,130 interactions that Health have, they go to the bed and say, "Do you mind if we take your blood", or "Bloods are due, can you put out your arm", because they are there in good faith. This is to pick up the people that are not there in good faith, Mr D'Adam—intentional, in our view.

The Hon. ANTHONY D'ADAM: I appreciate that.

Mr LITTLE: From our point of view, and I take on all of those examples, the frustration for our members is that this is inside a correctional setting. These are people who are already incarcerated. It is already a dangerous environment—particularly at some centres, I can assure you. It will add another element of exercising safety in that centre because it is not just about reducing attacks on officers, inevitably—and I will include juvenile facilities in this—it will bring better order to those centres because for people that want to engage in what is the most filthy, cowardly acts, there will be a consequence. We are not talking about whether it was intentional. These are cases where people have deliberately walked up and spat in their face. I do not want to go into the details of other times when bodily fluids are exchanged with our members in circumstances which would appal people. It is clear that it is deliberate.

That officer has to assume that they have just been infected. They cannot continue normal relations with their family. It is a three-month period for them to be cleared. They may have children, or whatever the case may be, and inevitably they end up in a situation, through no fault of their own, where they have a psychological injury. This bill will help to reduce that, in our view. In other jurisdictions it has been brought in and, for the life of me, I do not know why it is—and, of course, we can always look at extreme cases, I understand that. We could sit here for a long time and give you extreme examples. It was not that long ago in the juvenile system that we had a massive riot, in March 2019. We had 12-year-olds housed with people up to 22. People do not often think about that. That is the reality. Our members had to manage that. This is another string in that bow which will help them do that.

The Hon. ANTHONY D'ADAM: One of the key issues is being at risk, and how much risk is actually there, so I wanted to ask about your understanding, whether there is data—perhaps there is not—about how many actual transmissions have occurred as a consequence of the circumstances that are anticipated by this bill.

Ms JESS: I do not have any data on that, but I would say there would probably be data in regard to post-traumatic stress disorder [PTSD.] from the amount of times that you are spat on—we have had some people spat on nine times in their career, 10 times bitten, had blood thrown at them, faeces thrown at them, urine thrown at them. That builds up over time, all that waiting, the three-month wait, over the career. I have been in the job

for 32 years and every time I have had to wait for a result. This bill would have alleviated the stress that I have had in that three months.

Mr LITTLE: Can I talk about the weaponisation? Obviously we now have a correctional centre named after one of our members who was murdered after being attacked with a blood-filled syringe and consequently died some years later—appalling circumstances. Many of his workmates continued—they are in the job now. As I said before, if they have an inmate walk up and spit in their face, they have to respect that person's privacy, yet if I walk out of here and am involved in a car accident, I have no option, I have to give blood. I have no option. We are talking about circumstances where quite often, in a correctional centre, it is a deliberate, malicious act.

The Hon. CATHERINE CUSACK: I did want to ask about the case of Geoffrey Pearce, if you could place that on the record, because it is relevant.

Mr LITTLE: Yes. I cannot recall the actual year—

The Hon. CATHERINE CUSACK: It was 1991.

Mr LITTLE: That is right, and obviously at Long Bay he was attacked with a blood-filled syringe. Some years later he succumbed from HIV. For our members, many worked with Mr Pearce.

The Hon. CATHERINE CUSACK: So the bill would require that the perpetrator had a test.

Mr LITTLE: Yes.

The Hon. CATHERINE CUSACK: That is literally what the bill does.

Mr LITTLE: Yes.

The Hon. SHAYNE MALLARD: They already knew that that inmate had HIV/AIDS; it was not a secret.

The CHAIR: Order!

Mr LITTLE: No, it was not. What occurs quite often in prisons is, depending on the situation, a Justice Health nurse may come up and say, "You need to go and get tested", but that may not happen and often does not.

The Hon. CATHERINE CUSACK: We already have a pretty extensive mandatory testing regime, do we not, for people entering the country? There are mandatory tests around COVID-19 at the moment. Is that correct?

Mr GOOLEY: That is correct.

The Hon. CATHERINE CUSACK: For a motorist being pulled over for a random breath test it is mandatory, is it not, to comply with that test?

Mr GOOLEY: Yes.

The Hon. CATHERINE CUSACK: In relation to an officer where there has been an exchange of fluid, irrespective of intent, is it not important health information for that officer to find out whether there was risk of illness associated with that incident? This actually puzzles me. I do not even understand why there needs to be intent if you are looking after the best interests of the officer—

Mr GOOLEY: We took a view that, in circumstances where it is deliberately applied, there is far less likelihood of the third party volunteering to do a test. Obviously the NSW Health department guidelines say that, if you are exposed, you should seek a test from the third party. Clearly, in circumstances where it is an assault or where this deliberately applies—if I can give you an example which personally happened to me, I had a deliberate exposure to blood from an offender. If I asked them, "Do you have any bloodborne diseases", I can tell you what I am going to get back, and it is going to be very rude and it is going to include every one of them, and it is going to include a wish that I obtain them all. Whether that is true or not, I do not know, but in the circumstances of an accidental exposure of an emergency services worker it is far more likely that they would comply.

The Hon. CATHERINE CUSACK: And that is essentially where your difficulties have arisen with people who are not cooperating with the police.

Mr GOOLEY: In the game of balancing rights, and we understand that this Parliament has a very strong obligation to balance people's rights, we felt that the line rightly sits with those that do it deliberately.

Mr BEAR: Through the process we have tried to work with the Parliament. That is where we have got to. We find that this has drawn a balance and that is why we say intentional. To be fair about the medical history, that is one, but there are two major parts. It is psychological and psychological, psychological that I can have in

my mind a quick result that might not be 100 per cent but is probably 95 per cent or something similar that is going to give me a little bit of peace of mind—just a little bit.

Mr GOOLEY: And will better inform my treatment.

The Hon. CATHERINE CUSACK: You do not need to persuade me of the need for it. What I am trying to understand is the way you talk about balancing rights; it is as if the test is some sort of punishment.

Mr BEAR: No, no.

The Hon. CATHERINE CUSACK: But do you see what I am saying? The purpose of the test is to get health information for the person who has been impacted.

Mr BEAR: Yes.

The Hon. CATHERINE CUSACK: It is not a judgement, in the way that mandatory random breath testing is not a judgement on every motorist on the road.

Mr BEAR: No.

The Hon. CATHERINE CUSACK: And COVID testing is not a judgement on every returning Australian. This is important health information. Why are we balancing rights on this one?

Mr GOOLEY: Because in negotiations with members of Parliament in previous committee processes and engaging with other stakeholders around this—

The Hon. CATHERINE CUSACK: Is there sensitivity?

Mr GOOLEY: It is about trying to get it through. We have come to a position where we believe we are in a position where we can balance the rights of our members and hopefully get this legislation up and running for the benefit of our members. It has been talked about and talked about. We have campaigned for 30 years as a union. It has been through the committee process for four years and we believe this strikes a balance. If the balance is taking blood once off an offender versus the dozens of tests I have had to have as an operational police officer, including an exposure and a second exposure before my last regime is finished, the one test on that offender, I think, needs to take a secondary place to the sacrifices that the injured worker goes through with dozens of tests. And I want my doctor to have the best information. If I am on prophylactic medication that is going to damage my kidneys and my liver. The indicator that there is a low viral load and that I can reduce that medication and preserve my life, that has to take precedence over this person who has deliberately applied the fluid.

The Hon. CATHERINE CUSACK: Hear, hear.

The CHAIR: I will pass questioning now to Mr Farlow for the five minutes we have left.

The Hon. SCOTT FARLOW: I have to say that Ms Cusack has asked many of my questions anyway, so that is very helpful. Thank you for that. It will cut down the time. But to this point and to the realities of getting this legislation through, ideally whether it is intentional, deliberate or accidental, the risk to your member does not change, so what we are seeing here is already effectively a concession and a balancing in order to protect the rights of an individual in being able to maintain their own autonomy and also trying to see some comfort for your members in being sure that they are not exposed to bloodborne disease when they are exposed to bodily fluids or they are exposed to a needlestick injury. Is that correct?

Mr BEAR: One hundred per cent correct.

The Hon. SCOTT FARLOW: And just going through some of the data that you have provided in your submission as well, you outline in the table the total instances of exposure to bodily fluids. There are 450 total incidents of exposure to bodily fluids that you have outlined there for police officers. Have you got any indication of how many of those would be captured by this legislation with the deliberate requirement?

Mr BEAR: No. The NSW Police Force may be next or on tomorrow and may well be able to give you that.

The Hon. SCOTT FARLOW: They might have some information on that? Okay.

Mr BEAR: We could take it on notice but you would have to manually go through. It would be very hard.

Mr LITTLE: Can I say that ours would probably be very high?

The Hon. SCOTT FARLOW: Very high?

Mr LITTLE: Yes, because generally they are deliberate acts.

The Hon. SCOTT FARLOW: I think in Corrective Services it is 130 that is outlined in the Police Association submission.

Mr LITTLE: That is for the last 12 months but over the last three years it was 400-odd.

Mr GOOLEY: What we can say, I am sorry—

The Hon. SCOTT FARLOW: Yes, go on.

Mr GOOLEY: —is that there is a very high rate—I cannot give you the exact figure—of psychological injury reported where the mechanism of injury was exposure to blood so the correlation between the psychological injury and the exposure is quite high. It would be a manual calculation for the Police Force about the deliberateness.

The Hon. SCOTT FARLOW: I think you outline in your submission as well what your members have undertaken. Mr Little, I think you have outlined that as well in terms of today—that they are not able to have contact with their family in the usual way for three to six months. I think in the Police Association's submission there is some mention there as well about potential medical courses they have to undergo in just that expectation as well, so to both the physical issue that members of the Police Force and members of Corrective Services undergo due to these exposures and also the psychological, what sort of benefits would you seek from legislation such as this who have undergone a needlestick injury or have been exposed to blood-borne disease?

Mr LITTLE: Could I start with that, Mr Farlow? Our members are told that they should assume that they have contracted hepatitis. As I said, hepatitis in a correctional centres is 20 to 30 sometimes 40 times more prevalent than in the community, so they are told, "You assume that you have contracted hepatitis. You assume that until you get that test", which is three months later. The effect of this, as I think Mr Bear said, is that within a couple of days we can give them 95 per cent certain that they have not contracted, particularly, hepatitis. That is really, for our members, is the big fit. We have members who were exposed to it during so-called slash-ups and having to respond, not through deliberate acts. That happens. That has happened. We know that but when it is, like, deliberate/intentional, these sort of acts quite often—it can go such a long way in reducing psychological injuries because they do not have to spend three months waiting to get the all-clear before they can have normal family relations.

Ms JESS: But it is also about the medication that you have to take whilst you are on it.

Mr LITTLE: Yes.

Ms JESS: You might not need to take as high a dose as what is required, and that medication makes you quite ill. When you are so ill you cannot come to work it impacts on the workplace with, you know, vacancies, workers compensation. Like, it is all a cost. This would reduce that dramatically.

The CHAIR: Unfortunately, we have reached time.

The Hon. TREVOR KHAN: Could I ask that—I think the Hon. Greg Donnelly has one—that at least another five minutes be allowed?

The Hon. SCOTT FARLOW: I have one as well.

The Hon. TREVOR KHAN: These are important witnesses.

Mr DAVID SHOEBRIDGE: I would support an additional 10 minutes.

The CHAIR: Can we impose on you to stay a little bit longer? Is that okay?

Mr LITTLE: That is fine.

The CHAIR: In that case, yes—if we can restrict the time taken to ask our questions. Mr Donnelly, the Deputy Chair?

The Hon. GREG DONNELLY: Thanks, Chair. Thanks for coming along today. In the Police Association's submission on the top of page 5, which I think has been commented on in passing in one of the answers given to one of the questions asked a bit earlier, refers to the other jurisdictions in Australia, and states:

> Many jurisdictions around Australia have adopted equivalent legislation designed for this objective (Western Australia, Northern Territory, South Australia, Queensland and Victoria).

In terms of that legislation or the legislation in those jurisdictions, it says "equivalent". Does that mean it is quite similar to what is being proposed and what we are looking at? If you need to take it on notice because you are not familiar with the terms—

Mr BEAR: All five have similarities. Some are strong. Some are weaker. As per usual for New South Wales, this is the best in the country.

Mr GOOLEY: What we are assured that it has the best review mechanism and oversight by the Ombudsman, the ability to review, and I am also instructed that one of the deficits in data from the other States is that they do not have the committee review process after 12 months, three years or five years on most legislation. So there are deficiencies in data on the results of the legislation and we think that this bill, through the involvement of the Ombudsman, strikes at the heart of: Is this working?

Mr BEAR: As well the simple fact that Mr Greenwich's amendment that correlates the data from any of the demographics that will come, which is a fair enough amendment. I think it was Mr Greenwich. It may well have been—

The Hon. TREVOR KHAN: Or Ms Leong?

Mr BEAR: Or Ms Leong. It was one of the two. Obviously they were putting those amendments up. But also in New South Wales we actually have the strongest oversight by the standing royal commission on anything that we do as police officers that any action the police take is oversighted. So, I hope that answers your question.

The Hon. GREG DONNELLY: Okay. Thank you.

The CHAIR: Mr D'Adam?

The Hon. SHAYNE MALLARD: No. Mr D'Adam has had plenty of time.

The Hon. ANTHONY D'ADAM: Yes. Mr Mallard has not asked any questions.

The CHAIR: Okay.

The Hon. SHAYNE MALLARD: Thank you, Mr D'Adam. Thanks for coming in today and I appreciate the submission. By and large the submissions that oppose this legislation say they support the intent. I had picked up on the psychological benefits and I think you said 95 per cent. But by and large if someone is exposed to a blood situation, which is the main thing we are talking about here—

Mr GOOLEY: Yes.

The Hon. SHAYNE MALLARD: Mr Gooley, you talked about a scenario where they go the medical practitioner and he or she says, "You have probably been exposed, and you assume in your situation you have been exposed." They will start the treatment, regardless. We will hear more evidence of that today but they will start the treatment regardless and the incubation period for hepatitis C, assuming all of your workers have been vaccinated for hepatitis B—that would be standard practice for front-line workers—is 60 to 90 days and for HIV it is 60 to 90 days, sometimes even longer. So there is no certainty that that blood test of that assailant is giving out a figure and the medical practitioner will most likely cautiously continue the same regime of medication, which you have described in detail on page 3 of your submission. Do you accept that?

Mr GOOLEY: Well, you are correct. There is a low risk in our submission—I absolutely accept that—and there is an exposure protocol that is best practice.

The Hon. SHAYNE MALLARD: Yes.

Mr GOOLEY: What is also best practice is, regardless of the method of transmission, that the third party be tested. Those tests are provided and form part of the risk assessment. There are two things. Things like viral load are important if there is a presence in a bloodborne virus or disease. I have had numerous exposures and numerous tests. I cannot obtain a hep B immunity. I have had numerous courses. Should I not be allowed to be a police officer because I cannot get a hep B immunity? No. Whilst everyone is vaccinated, those vaccinations are not 100 per cent. I am an equivalent of the same proportion of people walking around in the community with hep B—I might be that miniscule amount. But the risk is real, it is there and the NSW Health department identifies it.

I will give you an example of an officer who has received a deliberate needlestick injury—a former officer. He was exposed deliberately; he was stabbed with a needle. He undertook post-exposure protocols that involved a combination of three drugs. On questioning, the offender claimed to have a particular bloodborne virus and the officer was treated accordingly. He suffered very serious side effects from the medication. He suffered a very serious psychological injury and is now living a very poor quality of life as a former police officer whose life has changed forever. He never developed the bloodborne disease that was claimed by the offender. His treatment would have changed had that offender been tested and those results provided. He was treated as the absolute worst-case scenario. Whilst a test of the offender would not have been definitive, it would have altered his treatment.

The Hon. SHAYNE MALLARD: We will hear that from the medical practitioner, but I accept that—

Mr GOOLEY: Yes. There is no standard treatment as such. It is based on risk.

The Hon. SHAYNE MALLARD: Ms Jess made a valid point that you could adjust the treatment based on—

Mr GOOLEY: Absolutely.

The Hon. SHAYNE MALLARD: —a negative result with a view that it might be positive within two to three months, particularly in a prison context with hepatitis C.

Mr GOOLEY: And similarly adjust if it does come back positive.

Mr BEAR: But we firmly acknowledge there is a window—

The Hon. SHAYNE MALLARD: But the point I am making is it is not going to really dramatically—

Mr BEAR: We firmly acknowledge—

The CHAIR: Order! Mr Mallard, we will let the witnesses answer as well.

Mr BEAR: We firmly acknowledge there is a window, yes.

Mr DAVID SHOEBRIDGE: But I think Mr Mallard's question was: Do you have medical evidence to show how it would change the treatment regime? Mr Mallard's proposition, which seems to be consistent with what everybody says, is that medical practitioners take a highly cautious approach regardless.

Mr BEAR: But Mr Mallard also said that the medical approach is also psychological. He accepted the fact that the psychological effects of taking the knowledge—even if it is 95 per cent, 85 per cent or even 15 per cent. Police officers are subject to so many highly fuelled events, whether it be for a SIDS death, whether it be large accidents or death. Mr Mallard, if as part of our organisation we can take a speck, one grain of a brick out of a wall of psychological illnesses then I call upon this Committee to do so. We are here today, and have challenged this for four years, on the grounds that it is 99 per cent of the psychological effects that we can help, both the PSA members and our members, to get a little bit of respite.

The Hon. SHAYNE MALLARD: That is where the balance is.

Mr BEAR: That is the balance.

Mr LITTLE: Can I add to the mental side of things? As we said, in the prison situation you are talking one in five. They presume the person has—

The Hon. SHAYNE MALLARD: Hepatitis C, you are saying?

Mr LITTLE: That is right. They are presuming that that person has it. When they get a negative test two days later their mental health is going to be a whole lot better than having to wait three months.

The Hon. SCOTT FARLOW: Just on that question, when it comes to the prison setting there is probably less likelihood of somebody developing a disease inside prison compared to outside in the community. Would that be right?

The Hon. TREVOR KHAN: I do not know if that is the case, actually.

Ms JESS: No.

Mr LITTLE: I would have to take that one on notice.

The Hon. SCOTT FARLOW: Okay, no, I am wrong with that. That is fine.

The CHAIR: Just in the brief time we have got left, Mr Khan has indicated he has something else, as did Mr D'Adam and Mr Shoebridge.

The Hon. TREVOR KHAN: Let us suppose you have got me over the line on clause 7. The next clause is essentially clause 10, which relates to who determines whether the matter should be the subject of an order. I get the feeling that there is an acceptance that the decision-making process first off obviously involves a medical practitioner, then a consultation by somebody—apart from the officer—that also involves consultation with the medical practitioner by, in the current form, a senior police officer or relevantly someone else in Corrective Services. Why should the determination not be made by a court as opposed to somebody who is in the direct line with the officer who has been the subject of what I will call "the injury"?

Mr BEAR: It goes directly to what we have said for the last four years—the timeliness of the act. Some 99 per cent of the time the person is already going to be in the custody of either the Corrective Services or us, or because of the deliberate nature of what they have done they will be in custody.

The Hon. TREVOR KHAN: I accept that.

Mr BEAR: That is the timeliness of the event: the fact they are already in custody. We do not have to go and possibly have a second or third time going and relocating the source person. You make the decision that the source person is tested, but the appeal process from there is applicable to the section 20 to 23 et cetera to make that decision so as to stop the results.

Mr GOOLEY: It is also consistent with a whole range of other legislation, including forensic procedures, police-issued interim apprehended violence orders, terrorism powers, road blocks and public order incidents. The gambit of the senior officer as a manager as opposed to a supervisor of these officers involves the management of a geographic area in terms of all public order. The senior officers within the NSW Police Force are well versed in exercising the power to assess this information and make orders.

The Hon. TREVOR KHAN: I am musing here, so you understand my thought. On the basis of the evidence that you have given already, particularly with regard to psychological injury, a concern that I would have is that the senior officer is almost in the position of making a decision against the interests of an officer who either directly or indirectly is under their control. Therefore, the potential is it becomes a simple tick and flick. I am simply putting that—

Mr BEAR: I disagree. The training of—

The Hon. TREVOR KHAN: I am giving you the opportunity—

Mr BEAR: —our senior officers these days is independent. I was a sergeant of police when I finished in work. What that meant is I was a custody officer in charge of prisoners that came into the police station. I was very careful to make sure that their rights were protected because that was my job. My job was not to then be a police officer. When a prisoner came in, my job was to make sure that the police themselves conducted themselves as per part 9 of the Act. Our job as police is to protect the community. It does not matter whether they are offenders or not. I took that job very, very seriously—and you are talking about one step above that. I think we have shown over a longer period of time with the amount of complaints that police put in on other police that we have grown up in Australia and in New South Wales. Given the training, given the expertise and given the oversight, I do not think that is a concern. As Mr Gooley has said—he was an inspector when he came over to us—we have so many other similar decisions to make but this is just bar one.

Mr GOOLEY: The very employment nature of a commissioned officer is different to that of a non-commissioned officer as well. There is a traditional reason why certain powers and responsibilities are reserved only for senior officers who are defined as commissioned officers. It is no denigration of the rank of sergeant but there is a clear delineation there between commissioned officers and non-commissioned officers.

The Hon. SHAYNE MALLARD: Do not take it personally.

Mr DAVID SHOEBRIDGE: But of course there is—

The Hon. TREVOR KHAN: It was, actually.

The CHAIR: Order!

Mr DAVID SHOEBRIDGE: But there is an unlimited delegation power.

The CHAIR: Mr D'Adam has indicated he has got a very quick question, which he can ask before we cease.

The Hon. ANTHONY D'ADAM: Mr Gooley, earlier in your evidence you indicated that medical practitioners might face criminal sanctions. Can you take us to the provisions in the bill that—

Mr GOOLEY: Sorry, it is not in this bill. I am saying in many other—most of your road transport legislation creates the offence of a medical practitioner—or, in the absence of a medical practitioner, a nurse—failing to take a sample of blood of a person involved in a motor vehicle collision.

The Hon. ANTHONY D'ADAM: But that is not the case in this bill.

Mr GOOLEY: No, and we would never intend it to be.

The CHAIR: I thank the witnesses for appearing today. Thank you very much for your patience during the technical difficulties and for your indulgence in staying a little longer. For questions that have been taken on

notice, the Committee has resolved that answers be returned to us within 14 days. The secretariat will contact you in relation to the questions you have taken on notice. We will now have a brief break before we hear from the next set of witnesses.

(The witnesses withdrew.)

(Short adjournment)

NICHOLAS MEDLAND, President, Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine, before the Committee via videoconference, sworn and examined

STEVEN DREW, Chief Executive Officer, Hepatitis NSW, affirmed and examined

NICHOLAS PARKHILL, Chief Executive Officer, ACON, affirmed and examined

KAREN PRICE, Deputy Chief Executive Officer, ACON, affirmed and examined

The Hon. SHAYNE MALLARD: In the spirit of declarations, just for clarity, I want to declare an interest to the Committee: From approximately 1995 to 2000 I was a board member of the AIDS Council of New South Wales [ACON] and for one year, from 1999 to 2000, I was the Vice President of the national peak body called the Australian Federation of AIDS Organisations [AFAO]. Both positions entailed extensive liaison and representation to Government over that time and with various people I know who are witnesses or who have made submissions to this inquiry. It is not a conflict of interest; I am just letting you know that I have that background.

The CHAIR: Thank you for the clarification, Mr Mallard. We have the opportunity for witnesses to start by making a short opening statement, so if you would like to, please do so, but try to keep your statement to no more than a couple of minutes. Dr Medland, would you like to start?

Dr MEDLAND: Yes, sure, thank you very much. As I mentioned, I am representing the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine. We are the peak body for the guidelines and clinical care and education related to bloodborne viruses and we are the authors of Australia's bloodborne virus testing protocols and policies. I am a researcher in HIV transmission elimination and a consultant physician in HIV and AIDS clinical care with more than 25 years' experience.

This proposed legislation is unnecessary because the vast majority of incidents covered in this legislation where a frontline worker comes into contact with bodily fluids carries zero risk of transmission, including all cases of spitting. When a risk does occur it can be identified through evidence-based risk assessment and, where required, management by medical practitioners with specialised knowledge and training in bloodborne viruses. Let me be very clear: New South Wales frontline workers are not at risk of bloodborne viruses under current protocols. There have been no transmissions to any frontline workers in 17 years and, when correctly followed, these protocols have never failed to prevent bloodborne virus transmission in frontline workers in Australia.

This legislation has been providing peace of mind to our frontline workers and we acknowledge the challenging situations they face every day. Window periods with the latest testing methods are weeks and not months. Hugging and kissing family members is never a risk. I understand that it may seem counter-intuitive to say that mandatory testing will not reduce the anxiety of frontline workers, but by perpetuating misinformation about how bloodborne viruses are transmitted and focusing on injuries which do not transmit viruses, the anxiety of our frontline workers may be increased. On the other hand, it can be reduced by educating workers about how bloodborne viruses are transmitted and ensuring that they have rapid access to expert assessment, support and management. If our workers do not understand the risks, the legislation will not help them, but their agencies can. Where psychological injury is concerned, the psychological injury should be the health and safety focus, not the transmission issue, which is already being adequately managed. Non-consensual testing is against medical ethics, Australian Government testing policy and good practice and may be physically dangerous and lead to further injuries and exposure.

New South Wales is leading the world in reducing community HIV transmission and hepatitis transmission with New South Wales Government leadership and funding. It has done this by rigorously adhering to the evidence and following the science, even when it may seem counter-intuitive—a message we have all been taught over the past year. We do not want to diminish the trauma of frontline workers in New South Wales who face violence on the job. We share the view that it is important to reduce their anxieties about bloodborne viruses. The current bill does not do that and may make those anxieties worse. We must follow the science. We fail our frontline workers if we pass this legislation. Thank you.

Mr PARKHILL: We welcome the opportunity to present evidence to this Committee today, thank you. At the outset I would like to state that our evidence comes from a perspective that acknowledges the difficult job that emergency workers undertake to protect and care for us all as well as from a perspective of compassion. We have over 35 years of understanding the concern and fear that comes with the risk of contracting HIV. There is no excuse ever for assaulting a police officer or an emergency worker; it is unacceptable. We support frontline workers and thank them for the often traumatic work that they do. We understand the compassion and desire of members of the New South Wales Parliament to want to help in this regard. We appreciate the emotional reactions

to incidents where frontline workers are exposed to blood and other bodily fluids. While we understand the intention of this bill is to help, the bill instead serves to provide false reassurance.

Mandatory testing will not make our emergency workers safer. Mandatory testing is a flawed response that will trigger harmful outcomes and erode the HIV leadership that New South Wales has provided both in Australia and globally. Our HIV response is recognised because it is evidence-based and has been backed up by successive New South Wales governments for over 35 years. The best way to reduce fear and anxiety is to educate people with accurate information. This includes a truthful account of the likely risk in the exposure event, clear evidence on timely prevention options and implications that the risk event may have for families and others. The best way to reduce fear and anxiety is good public health information and clear care pathways. This has been our approach to exposure up until now and has been a proven strategy again in relation to COVID.

HIV evokes fear based on outdated myths and misinformation. At ACON we understand all too well the fear associated with that. When we were established in 1985 as a community response to AIDS, our loved ones were dying and there was much that we did not know about this disease or the epidemic. Today at our HIV and sexually transmitted infection [STI] testing centres we still see people who remember the grim reaper ads of the 1980s. Some people still ask us if they can get HIV through kissing, from touching or from spit. Some clients have still very fear-based misunderstanding around how transmission occurs. What we do to address those fears is to provide clients with information about the reality of risk today, and that reality is that the speed and scale of changes in the HIV landscape over the last 35 years in this State have been extraordinary. We know now precisely how HIV gets passed on and how it does not. We now have treatment so effective that people living with HIV can live long and healthy lives, and those that are on treatment do not pass on the virus.

In New South Wales 98 per cent of people with HIV are on treatment and those who are newly diagnosed get put on treatment within weeks. This means they cannot pass on the virus. The evidence tools and the public health infrastructure we have in this State are so advanced and sophisticated that we can realistically end transmission soon. HIV prevalence in this State is one of the lowest in the world and we continue to see dramatic drops. From January to September in 2020 the number of new residents acquiring HIV was 155, a decrease of 31 per cent compared to the average of the previous five years. Those diagnosed were not spread evenly across New South Wales or across all population groups. Only three of those identified were Aboriginal and Torres Strait Islander people, none were under the age of 15 and nearly 90 per cent lived in Greater Sydney or Newcastle.

While there is a distinct lack of information and accountability in the public domain about mandatory testing laws in some States, we do get a sense from other places where this law exists that it potentially targets those people living in rural areas or people who are more likely to encounter police and emergency services. We are aware of arguments that reference our concern about this legislation not coming to fruition based on the experience of other States, but it is difficult to say how that can be said with confidence. HIV sector partners in Australia have tried to find out how the law, where it does exist in other States, has prevented transmission to frontline workers, but that information is not available, nearly impossible to access.

What can be said though is that hundreds of people in the case of Western Australia have been subjected to State-enforced medical procedure without transparency or appropriate oversight. Members of this Committee will know that some groups do come into contact disproportionately with police and other emergency workers, and therefore will be more subject to State-sanctioned testing—people such as homeless people, people with mental health issues and Aboriginal and Torres Strait Islander people. These populations groups are not at high risk of HIV but they are already disadvantaged and they require clear pathways rather than additional criminalisation interventions. We have a world-class public health response in New South Wales. We have seen zero occupational transmissions of HIV in 17 years and that is something that needs to be maintained.

It is bewildering and disheartening to see what we believe is a fear-driven proposal being considered in this place—a place where, in response to another pandemic, evidence reigns, and Government intervention is taken only when necessary. This bill disregards the advice of doctors, epidemiologists, and public health experts and is contrary to international and our own domestic policies and protocols. It creates unnecessary costs to an already stretched health system. It will allow testing to occur where this is no risk of transmission. It will allow testing to go ahead without medical advice and, strangely, includes references to bodily fluids, such as saliva, that carry no risk of HIV transmission. HIV simply does not get passed on through saliva, sweat, tears, mucous, vomit, urine or faeces. It does not get passed on through spitting.

The CHAIR: Excuse me, Mr Parkhill. Can I inquire how much more you have?

Mr PARKHILL: I will wrap up now. It was unnecessary in the nineties and it is unnecessary now. Parliament should be a place where good public health laws are passed to improve the lives of citizens. It should not be a place where an uninformed pub test approach to legislation is taken. Again I say, as I conclude, we offer this evidence and statement as an act of solidarity with the workers in the scope for this bill.

The CHAIR: Thank you, Mr Parkhill. For the benefit of Hansard, could you pass your opening statement to the secretariat so that it can be used in the transcript?

Mr PARKHILL: Certainly.

The CHAIR: Mr Drew, would you like to make a statement?

Mr DREW: Yes. Thank you, Chair. Hepatitis NSW welcomes this inquiry and thanks the Committee for the opportunity to present and give evidence. We, by whom I mean our members—people with the lived experience of hepatitis and partner services—have a lot at stake in relation to this bill. Two of the three blood-borne viruses covered by the bill are hepatitis viruses after all. At the outset I want to place on record that we too absolutely support our front-line Health and emergency service workers. We partner with many of them in the course of our work every day. We believe they should not wantonly be subjected to unnecessary threats or risks as they go about their job serving the New South Wales community. It is abhorrent that attacks do occur that create health-related stress and concern.

Hepatitis NSW is working towards a world free of viral hepatitis. We are part of a concerted effort by the community, government and health sectors to eliminate both hepatitis C and hepatitis B in New South Wales by 2028. It is hard grafting work to reach our audience. However, efforts to date have resulted in ongoing decline in prevalence of both hepatitis B and C. The bottom line is this: both hepatitis B and C is a numerically small and ever-diminishing health risk in New South Wales. This bill will potentially make it harder for us to reach the very people we need to to make good on elimination. New South Wales is seen as a world leader in evidence-based responses to health epidemics including HIV and viral hepatitis. In the interests of maintaining New South Wales's first State position as a leader, not a follower, the first steps in protecting and promoting the health and wellbeing of our front-line workers should reflect our world-leading response to public health issues.

Medicine has moved way ahead from where this proposed legislation is founded. We have a cure for hepatitis C and a vaccination for hepatitis B. This means the fear and worry validated by this legislation is simply not justifiable and therefore the legislation is unwarranted. We need to ensure that our vitally important, valuable and respected front-line workers are reassured by experts and specialists in the field that, based on science and evidence, the likelihood of the transmission of a blood-borne virus as a result of spitting or contact with blood is virtually non-existent. The importance of protecting the health and wellbeing, including mental health and wellbeing, of staff, employees, workers and indeed the general public is something we can all agree on. As workplaces we have an obligation to do all that we can to protect our staff from injury and harm in the course of their duties.

The rationale for this bill is to protect and promote health and wellbeing of front-line workers. We already have the tools to do so. They are the workplace health and safety and public health legislation and regulations, actioned and supported by policies, guidelines and procedures developed by agencies and departments to meet these obligations. The system is already set up. It places the health and safety of the worker at the centre of risk assessment and prevention and prioritises evidence-based assessment, treatment and care. Focus should be on the access to immediate assessment of risk by a qualified health practitioner, counselling and support to the person along with the commencement, if appropriate, of recommended aftercare procedures and treatments, including post-exposure prophylaxis. Requiring an alleged assailant to undertake a blood test does not provide peace of mind. It is an unnecessary substitute for immediate clinical assessment of the worker by an expert.

It is important to state clearly and unambiguously that progressing this bill through Parliament until assent will likely disproportionately adversely affect already disadvantaged populations, being street-present and marginalised people—specifically Aboriginal and Torres Strait Islander people as well as people with addiction and gender identity and mental health issues. This bill does not offer an increased peace of mind to our front-line workers yet would expose predominantly marginalised individuals to unnecessarily and invasive blood testing, potentially inflaming violent behaviour and increasing the risk of injury to both the person in custody and the front-line worker. It is on this basis that we say the legislation is unnecessary, inappropriate and therefore an unacceptable response to a highly unlikely health risk.

The CHAIR: Thank you, Mr Drew. Likewise, would you mind passing your opening statement to Hansard? Just noting the time, we are due to finish this session at 11.50, which only gives us about 33 minutes for questions. Mr D'Adam will open the questioning.

Mr DAVID SHOEBRIDGE: Can I propose we go through to 12 o'clock?

The Hon. SCOTT FARLOW: We have another witness after this.

The CHAIR: We have witnesses after this. Mr Shoebridge, it was your resolution.

Mr DAVID SHOEBRIDGE: I am happy to chop five minutes off lunch. Can we chop lunch?

The CHAIR: We will see how we go. Mr D'Adam?

The Hon. ANTHONY D'ADAM: Thank you for your appearance today and thank you all for your submissions. I wanted to start firstly with Dr Medland. In your opening statement, I think you made a statement along the lines of there being no workplace transmissions. I understand that to be the case in terms of HIV but is that the case for hepatitis B and hepatitis C?

Dr MEDLAND: Sorry, I meant HIV transmissions. I am not aware of any hepatitis C transmission. Are you aware of some? I am sorry, I did mean HIV transmissions. My apology.

The Hon. ANTHONY D'ADAM: HIV, okay. I just wanted to clarify that. My second question is really about a post-exposure prophylactic. We heard some evidence earlier from the Public Service Association that the treatment actually has a number of side effects. I suppose I really would ask if you could perhaps just elucidate the nature of that treatment, particularly if there is an exposure where you are unsure about whether it is a HIV risk, a hepatitis C or—is there a prophylactic for hepatitis B?

Mr DREW: It is the vaccination itself.

The Hon. ANTHONY D'ADAM: Right.

Dr MEDLAND: There is a [audio malfunction] vaccination, yes.

The Hon. ANTHONY D'ADAM: So if there is exposure where you are unsure about what the particular blood-borne virus is that you are treating, the combination of post-exposure prophylaxis [PEP] for all three or all two conditions and what the consequences are for the person who is on that treatment regime in terms of side effects, perhaps you could elaborate on that?

Dr MEDLAND: All front-line workers are vaccinated against hepatitis B. Hepatitis C is a curable infection and there is no post-exposure prophylaxis for it. HIV, the most important part of HIV post-exposure prophylaxis is to identify those injuries or those exposures in which a risk occurs. These are very uncommon in front-line workers. They occur rather more frequently in healthcare workers but they are very uncommon in healthcare workers. So this legislation does not just deal with those severe exposures. This legislation is dealing with all of these exposures so if the legislation did focus only on blood as a body fluid and only focused on exposures where a trained medical officer was able to establish that there was a risk and the patient required post-exposure prophylaxis it would in some way be justifiable. But when we are dealing with biting, spitting and scratching which do not carry a risk, I cannot see what mandatory testing would do to that. The assessment is based on the exposure risk and then involves some medications that are taken for 28 days. They are well tolerated in most patients but they can cause fatigue, tiredness, nausea and headache.

The Hon. ANTHONY D'ADAM: There was a suggestion in the evidence earlier that they cause liver and kidney damage. Is that correct?

Dr MEDLAND: Very rarely. These are medications that if taken very long term by people living with HIV can increase the risk of kidney and liver damage. This is in patients who take them for years. It is extremely rare in patients who take it for 28 days. It may be monitored in the course of that but it is very, very, very rare indeed.

Mr DAVID SHOEBRIDGE: Dr Medland, you are a clinical epidemiologist, is that right?

Dr MEDLAND: I am a clinical HIV/AIDS specialist and I do research in epidemiology.

Mr DAVID SHOEBRIDGE: In terms of the transmission of HIV from saliva, can you explain to us what the risk is?

Dr MEDLAND: Yes. Saliva is not an infectious fluid in terms of HIV; blood is the infectious fluid. Saliva is actually designed as a barrier in our mouth. Saliva is designed to make our mouth safe. It is considered that spitting does not carry a risk of HIV transmission, nor contact with saliva.

The Hon. SHAYNE MALLARD: And kissing.

Mr DAVID SHOEBRIDGE: That would extend to kissing and also biting, I assume? Is that right?

Dr MEDLAND: With biting, the vast majority of cases have no risk whatsoever. I understand you have got a transmission expert, Professor Grulich, giving you evidence this afternoon.

Mr DAVID SHOEBRIDGE: Yes.

Dr MEDLAND: But I understand that it is considered that a single episode of a bite has got a negligible risk of HIV transmission.

Mr DAVID SHOEBRIDGE: So spitting and kissing, zero, and a single bite negligible for HIV?

Dr MEDLAND: Yes.

Mr DAVID SHOEBRIDGE: Could I ask those other witnesses we have here about hep C and hep B?

Mr DREW: Yes. In terms of hep B and hep C it is exactly the same: There is no transmission that we are aware of, in terms of our research, being passed on through saliva—kissing, biting—at all for the same reasons that Dr Medland has outlined. As one of my colleagues and friends at the Kirby Institute made the comment in terms particularly of hepatitis B, if you cannot get hepatitis B from deep pashing your partner you are certainly not going to get it from spitting.

The Hon. SHAYNE MALLARD: Because it is a bloodborne virus.

Mr DREW: Correct. They are both bloodborne viruses so it is not going to happen.

The Hon. SHAYNE MALLARD: As is HIV.

The CHAIR: You might need to speak into the microphone a little bit, just for Hansard.

Mr DAVID SHOEBRIDGE: From a medical point of view, would the testing of somebody who had spat upon an emergency service worker for HIV, hep B or hep C have any rational impact upon the course of treatment for the person who was spat upon?

Mr DREW: No, not that I am aware.

Dr MEDLAND: No.

Mr DAVID SHOEBRIDGE: We heard from the police and the PSA that if the test came back negative that that would lead to a reduced protocol, a reduced use of drugs or post-exposure prophylactics. Is there any medical foundation for that assertion by the PSA or the police?

Dr MEDLAND: Post-exposure prophylaxis would never be used if there was a spitting accident—never.

The CHAIR: Just for clarification, what if they were spitting blood? We heard some evidence earlier that people were actually biting the sides of their cheek and then spitting so they were—

The Hon. TREVOR KHAN: Well, that was the assertion.

The CHAIR: Yes, that was the assertion. Correct, Mr Khan. Spitting blood would obviously require the use of prophylactics?

Dr MEDLAND: No. We are talking about blood contamination of saliva. If that contacts the skin of the face I think it would be very unlikely in that scenario—this would be assessed. Every case would be assessed. If a police person has been injured they need to talk through this. I am not going to say that you could not come up with a scenario in which this might occur. We could extrapolate to some scenario in which it would occur. But in the vast majority of cases, even if there was bloodstained saliva spitting at somebody there would not be post-exposure prophylaxis given.

Post-exposure prophylaxis is given to penetrating injuries with medical instruments, to sexual exposures—this is the way HIV is transmitted and that is where post-exposure prophylaxis is used. If the person is anxious—and of course they are anxious—treating a minor exposure as if it is a major exposure is not going to make them less anxious. I should say there is no evidence that that is the case. If there was evidence, we will come back here and we will discuss it again. But there is no evidence that treating minor exposures as if they are major exposures makes people feel less anxious, however intuitive it might seem.

The Hon. TREVOR KHAN: Sorry, that was with regard to HIV. Can that be repeated in terms of hepatitis, just so we are clear?

Mr DREW: Yes. I would defer to Dr Medland because I am not a medical practitioner, but the same rules apply. Hepatitis B and hepatitis C are bloodborne viruses. It requires blood-to-blood contact. It requires a viable route of entry into the body that Dr Medland referred to—some sort of significant cut or wound—for that to occur. But I would reiterate the comment I made earlier that frontline workers are vaccinated against hepatitis B. They are immune to hepatitis B. Even with a viable route of entry they will not contract hepatitis B. Hepatitis C is a bloodborne virus. If there is a viable route of entry then the chances of contracting hepatitis C are higher, yes. There is also a treatment. It is an absolute cure after either eight to 12 weeks, depending on the course you are put on, taking a tablet a day—and you are cured.

Mr DAVID SHOEBRIDGE: But when you talk about a viable point of entry you are talking about blood to blood, not saliva to blood?

Mr DREW: Correct.

Mr DAVID SHOEBRIDGE: Spitting on a cut has zero risks.

Dr MEDLAND: Yes, needles.

Mr DREW: Absolutely. We are talking blood to blood, not saliva to blood.

Mr DAVID SHOEBRIDGE: Just to be clear: If somebody with HIV, hep B or hep C spits on a cut or an open wound of an emergency service worker, even in that case is it your evidence that there is zero risk of transmission?

The Hon. TREVOR KHAN: Sorry, there was some nodding there.

Mr DAVID SHOEBRIDGE: Is there nodding?

Mr DREW: Yes.

The CHAIR: Sorry, Hansard does not pick up nodding.

Mr DAVID SHOEBRIDGE: I missed it too, Dr Medland.

Dr MEDLAND: Pardon? Sorry, so we are talking about spitting into an open wound?

Mr DAVID SHOEBRIDGE: Yes.

Dr MEDLAND: As I said, there would need to be a risk-by-risk assessment. The doctors are very cautious. We probably do treat people with post-exposure prophylaxis but I would say that, on the whole, no.

The Hon. ANTHONY D'ADAM: Particularly with relation to hep C, we heard earlier evidence about the incidence in prisons—I think one in five was the statistic relating to prevalence. If it is curable, why is it so high in prisons?

The Hon. TREVOR KHAN: That is a very interesting question.

The Hon. SHAYNE MALLARD: They are working on it.

Mr DAVID SHOEBRIDGE: There is a program.

The Hon. ANTHONY D'ADAM: I have a follow-up question on hep B. Perhaps you can elaborate on your knowledge of the management of hepatitis in our correctional system, but is it the practice for inmates to be offered vaccination to hep B?

Mr DREW: I think it would be best to direct that question to the Justice Health and Forensic Mental Health Network at NSW Health. What I can say is that they have done a comprehensive program around encouraging the testing and treatment of inmates for hepatitis C in particular. In fact, they achieved effective elimination in four custodial correctional centres. It can and it does happen. In terms of hep B, in our submission I noted that there has been a comprehensive vaccination program that has been put in place by NSW Health since 2000. We literally have an entire generation from about the age of 25 down that is immunised against hepatitis B. They are immune; they will not pass on any virus because they do not get it and they cannot have it. The majority of people living with hepatitis C are actually out in the community. They are the people over the age of 50. We need to bear this in mind when we talk about the hep B and hep C viruses at the demographics of the people involved and the likelihood of them coming into regular or aggressive contact with frontline workers.

The Hon. SHAYNE MALLARD: Mr Drew, is it the case that there has been a focus on the juvenile justice setting in trying to vaccinate and eliminate hepatitis C and vaccinate for hepatitis B?

Mr DREW: Certainly in terms of hepatitis C, the juvenile justice system is also part of the remit of Justice Health and the forensic mental health network, so yes, they have undertaken catch-up vaccination programs for hepatitis B and facilitated access to treatment for hepatitis C.

The Hon. TREVOR KHAN: I asked a question of the last witnesses with regard to who essentially should make the order. Let us suppose, even on the basis of the evidence that we have now received that there are circumstances where there may be a risk, albeit unlikely, because the answer was that it should be a senior police officer because of the issue of timeliness, is there a reason why, for instance, the Chief Medical Officer or delegate or a magistrate should not be the one to consider the evidence and then decide whether an order is made?

Dr MEDLAND: The assessment of risk needs to be timely and, if there is some management of that risk, that needs to be immediate. I can see no reason why the testing would need to be immediate. The most important thing is that it should be only done where it is warranted. There are very different models of this across the country. In Western Australia where it is supported by policemen there have been more than 400 cases in the first three years. In Victoria, where it has to be ordered by the Chief Medical Officer, the power has never been used. I do not know if Victorian policemen are more anxious than Western Australian ones as a result, but I think we are really going down a model that is rarely used.

Ms PRICE: From ACON's point of view, I would like to add to Dr Medland's comment in the sense that it has always been ACON's position that a person with medical training and appropriate medical skill, knowledge and experience should be the one making the decision. It has also been the submission that we put into this inquiry, and therefore a matter of record, that we suggest that there is probably an insufficient level of education and knowledge, and I think partially that is one of the precipitating factors that has led to this situation, but I think we need to have educated, trained people who are appropriately equipped to make the decisions, noting the broad range of potential factors that could result in an exposure, the fact that the exposure has to be blood to blood—there is a whole range of factors to go into that. I think it is an appropriate check and balance that a medical professional make that decision rather than a police officer, who may or may not have had appropriate training.

Mr DAVID SHOEBRIDGE: I think we have seen how effective the Office of the Chief Medical Officer has been in the last 12 or so months. The Chief Medical Officer or a relatively qualified senior health officer who is delegated by the Chief Medical Officer is the kind of model you think—

Ms PRICE: Indeed. That model exists in a range of other legislation that operates in New South Wales, for example delegations that exist for the Chief Health Officer in relation to mental health and in relation to a whole range of other areas of health, so this would not be unusual in that regard and therefore would facilitate more timely assessment.

The Hon. TREVOR KHAN: The bill provides that for vulnerable people the order be made by a magistrate. I think it is part 4. On the basis of what you say now, is part 4 wrong because a magistrate is actually not the right person to be making it in relation to a vulnerable person? I know we have talked in terms of children, but "vulnerable people" seems to be a wider category than that. Is part 4 wrong in nominating a magistrate as opposed to the Chief Medical Officer?

Ms PRICE: In relation to timeliness, obviously magistrate access is a bit problematic. I would not be so bold to suggest anything in here is more wrong than some of the other sections of the bill, to be honest, but I would say that it is important that expertise is brought into the decision about whether to mandate a test on someone against their will, perhaps a magistrate in receipt of information from a health professional, but I guess in relation to HIV what happens to the person who has been potentially exposed does not change. We have to administer basically PEP [post-exposure prophylaxis] within 72 hours, so whatever process we put in place needs to keep that at the forefront of our mind because that is what we do now, that is the most effective way to prevent exposure and, to be frank, it does not matter if the mandatory test comes up with a negative result, the same precaution should apply because that could be a false negative.

It could be in the period where the person is sero-converting. If it is a positive result on the mandatory test or a negative result, the same procedure should apply. Universal precaution has got us to this point where we rarely—in fact never for many workers—have had an occupational exposure, so whether it is a magistrate or whether it is a doctor or whether it is both of them consulting with each other that mandates the test, the treatment of the person at the other end of this, the frontline worker, actually has to be the same. To your point about whether it is wrong to involve a magistrate, I think magistrates play an important role to uphold a range of rights of individuals in our community, so it is not necessarily wrong, but I think these decisions should absolutely be made on the basis of medical advice.

The Hon. TREVOR KHAN: If I look at the bill, the officer—I will use that terminology—has to make the application within 24 hours, has to have seen a medical practitioner and then, if an order is made, the third party has 48 hours under the bill to comply with the order. Assuming that there is no delay in terms of the senior officer making the order and serving the order, it seems to me there is a 72-hour window between the event and the timeframe expiring before physical force can be used, so what has happened to the officer during that 72 hours whilst waiting for the third party or accused to comply with an order?

Dr MEDLAND: This would not be useful in the short-term assessment of the risk, so the decision about how to manage the risk needs to be made before any of this has occurred. The legislation does not specify that the medical officer you consulted needs to be in any way a specialist or experienced in this area; they need to consult a medical officer, but it does not specify that the medical officer needs to request the test. It would be calamitous—absolutely calamitous—if waiting for these tests caused people to delay that assessment and management.

However this is implemented, it must be clear that this is something completely different from the risk and how the risk is managed. The current protocols work. Please, whatever you do, do not upset the apple cart of these protocols, which are protecting our officers.

Mr PARKHILL: I think it speaks too broadly as a principle. The New South Wales Government, over 35 years, to HIV and bloodborne viruses has largely been based on a public health response rather than a criminalised response and I think that public health response has served us all well, particularly those populations who are most at risk of transmission, and that is not emergency personnel, that is affected communities who are already largely marginalised. Using a public health approach rather than a criminalisation approach allows Government to engage with those populations and work with them to facilitate testing and to reduce transmission, not to push things down a criminal pathway or a law and justice pathway.

The Hon. SHAYNE MALLARD: I have two separate issues to raise. First of all, Dr Medland, thank you for your expert medical advice here today. In your submission for the Australian Society of HIV, Viral Hepatitis and Sexual Health Medicine [ASHM] you say that you are concerned that mandatory testing laws may place healthcare workers carrying out testing orders in unnecessarily dangerous situations, that is to say, it would increase the danger to healthcare workers. Can you expand on that and maybe briefly take us through how you would extract blood from an unwilling person?

Dr MEDLAND: I have no experience or training in how to extract blood from an unwilling person and I hope I never have to do that.

The Hon. SHAYNE MALLARD: Okay.

Dr MEDLAND: I should imagine—if it came to force— both me and the people restraining the person would be at risk. And would it not be an irony, if investigating a lot of risk exposure, myself or the officers experienced a high-risk exposure?

The Hon. SHAYNE MALLARD: You are essentially saying a needlestick injury or something similar.

Dr MEDLAND: Yes.

The Hon. SHAYNE MALLARD: All right. Thank you for that.

Mr PARKHILL: May I add something to that?

The Hon. SHAYNE MALLARD: Yes.

Mr PARKHILL: I think we do hear anecdotal evidence coming out of Western Australia from a lot of healthcare professionals that the police often find it difficult to find a healthcare professional to undertake the test because they do not feel, professionally, ethically, that they should be forced to take a test on someone who does not want to have a blood test done. In effect, what it does is create a policy setting where you have the health system on one hand opposing it and the police or law enforcement or emergency personnel on the other hand, and it makes the implementation of that policy very, very tense and a divisive space for them to operate in. That creates anxiety. It creates greater risk to those front-line health professionals. It triggers a set of other unintended outcomes that need to be thought about.

Mr DAVID SHOEBRIDGE: Having the decision-making about whether or not a test is done situated within the health system with a Chief Medical Officer would greatly alleviate that tension, would it not?

Mr PARKHILL: I would imagine it would because, yeah, with a health risk assessment.

The Hon. SHAYNE MALLARD: My second question is directed to both organisations and it is a bigger question. Mr Parkhill you said it was not necessary in the nineties during the grim reaper period. There was pressure to have compulsory testing. There was a member of Parliament here who wanted positive gays locked up in Alice Springs.

Mr DAVID SHOEBRIDGE: Shame.

The Hon. SHAYNE MALLARD: We have come a long way there, and congratulations to ACON for that work and for getting there. It is the same with hepatitis. It was a long journey in removing discrimination. Is there anxiety in the communities you represent about revisiting? I have been hearing about spitting. That was put to bed in the nineties about catching HIV from spitting. Is there anxiety in the communities you represent about this criminalisation of this and the compulsory testing regime that you did not need to do before?

Mr PARKHILL: I will hand over to Ms Price to speak to some of the issues around HIV stigma and discrimination, which are very, very real and persist today.

The Hon. SHAYNE MALLARD: But also Positive Life for many.

Mr PARKHILL: Absolutely and you can speak to Positive Life around this. The grim reaper campaign did a very, very good job at making most Australians very, very fearful around HIV. It was really those early years of the HIV response that we had national broadcast campaigns talking about HIV. The Government then changed tack and it kind of focused on at-risk population groups. What that has created is a very engaged set of populations that are at higher risk in managing that risk and responding to it, but more broadly the Australian populations still have a very outdated understanding about what HIV transmission looks like grounded in the grim reaper context and history. But for our communities, HIV stigma and discrimination is still very much real because it occurs, particularly for positive people, on a daily basis. It occurs in health settings, it occurs in, you know, criminal and justice settings. So that is something that cannot be underestimated in relation to this bill and indeed I think is driving some of the thinking behind this bill. Ms Price might like to speak to some of this.

Ms PRICE: Just briefly, ACON released a paper and we would be happy to table it as evidence around World AIDS Day on 3 December 2020 talking about ending HIV-related stigma for all and what it would take. Basically, in a nutshell, HIV stigma prevents people from wanting to come forward for testing. It prevents early initiation or in fact initiation at any stage on treatment. It prevents disclosure and proper consultations from being had, and the more you push these things under veils of secrecy or you prevent people getting the health care they need, you have actually increase the risk, not only to that person but to the rest of the community. It is a very interesting parallel experience that we are having at the moment—COVID—that we are trying not to demonise people who contract COVID-19. We ask them to do certain things in relation to protecting them for their own health but also for the health of the community.

It is important, I think, to reflect on that. Basically HIV stigma and while there was a short-term impact of the grim reaper campaign, the long-term legacy of that campaign has been incredibly damaging. These sorts of pieces of legislation that are not evidence-based fuel fear, perpetuate myth and stigma and make people who are HIV-positive or hepatitis B or hepatitis C positive less likely to have appropriate conversations, less likely to engage in treatment, and that is the exact opposite of what the public health community wants. It is also the exact opposite of what our front-line workers need in relation to their safety, should incidents occur.

The CHAIR: In the few minutes we have left, I will pass to Mr Roberts.

The Hon. SHAYNE MALLARD: I think the hepatitis council might like to add to that conversation because of similar experience.

The CHAIR: Okay. Could you just provide a brief response because we have only a few minutes left and Mr Roberts has some questions?

Mr DREW: Absolutely I would second the comments that my colleague Ms Price has made. The reality is, yes, there is absolutely stigma and discrimination for people living with hepatitis B and hepatitis C. There is a lot of stigma within the community itself. In terms of hepatitis B it is predominantly in Australia in people among culturally and linguistically diverse communities and there is a huge amount of internalised stigma and discrimination that goes on. Similarly in hepatitis C internalised stigma and discrimination, but the experience particularly of people with hepatitis C of the health, the justice and the welfare systems in relation to way they are treated or feel that they will be treated at the disclosure of their hepatitis status is very real and it does impact adversely on our endeavours to eliminate hepatitis C and hepatitis B by 2028.

The Hon. SHAYNE MALLARD: Thanks for that.

The CHAIR: Thank you. Mr Roberts?

The Hon. ROD ROBERTS: Thank you, Chair. Dr Medland, I might direct my question and proposition to you, if you do not mind. We just heard in this hearing this morning how effective the Chief Medical Officer of New South Wales and the Department of Health have been in the handling of the current COVID pandemic and their response to that. Taking that into account, how do you reconcile the Department of Health's policy directive to their workers? At 5.2 in their document, it states: "If a blood-borne status of a source patient at the time of an incident is unknown the staff conduct a risk assessment, should arrange for the source patient to be tested as soon as practicable for HIV, HPV and HCV infection. Results of source testing will better inform the exposed healthcare worker about risk of transmission and, where PEP has been initiated, inform the need for continuation." So, on one hand we are praising the Chief Medical Officer in NSW Health. What do you say about this statement in relation to this?

Dr MEDLAND: Yes, sure. So the types of injuries that healthcare workers sustain are much more likely to carry a larger and substantial risk of HIV and blood-borne virus transmission. They perform exposure-prone procedures, they are working in surgical cavities with sharp instruments with needles and the like. So it is widely acknowledged that the sorts of injuries or the spectrum of injuries that front-line workers experience are completely different. Let us say, for example, that this legislation wanted to focus just on those most severe injuries

that had been decided by a healthcare worker, appropriately experienced, that required post-exposure prophylaxis then I think you could maybe begin to justify it. But the umbrella of this legislation covers all those injuries in which there is no risk occurring. In the healthcare sector you will never see a patient approached for consent for testing if they spat or scratched or had bitten a patient. It would be a cardiology patient, someone inserting a central line which the healthcare worker was stabbed by. It was deep penetrating injury from a bloody object and it carries substantial risk.

Even in that case that health directive is very clear that if consent is not given, it cannot be performed. But there is a potential benefit in those most extreme cases and I think you could potentially make a case, which is not made by this legislation, for that issue.

The CHAIR: I would like to thank all the witnesses for appearing today. There was an offer to table a document but I do not believe there were questions on notice. If there were, they should be returned within 14 days. Thank you very much.

(The witnesses withdrew.)

(Short adjournment)

CAMERON COX, Chief Executive Officer, Sex Workers Outreach Project, affirmed and examined

ANDREW GRULICH, Head, HIV Epidemiology and Prevention Program, The Kirby Institute, UNSW Sydney, affirmed and examined

JANE COSTELLO, Chief Executive Officer, Positive Life NSW, sworn and examined

MARY ELLEN HARROD, Chief Executive Officer, NSW Users and AIDS Association, affirmed and examined

NEIL FRASER, Deputy Chief Executive Officer, Positive Life NSW, affirmed and examined

KALI KANIVALE, Special Projects and Advocacy Specialist, NSW Users and AIDS Association, affirmed and examined

The CHAIR: I welcome everyone to the third session of today's hearing. Would anybody like to make a short opening statement? I ask that you keep it to no more than a couple of minutes.

Dr HARROD: Thank you for this opportunity to provide evidence to this inquiry. The NSW Users and AIDS Association [NUAA] is a peer-based organisation that represents people who inject illicit drugs in New South Wales. We have worked with NSW Health for over 30 years to support evidence-based and effective responses to prevent and treat bloodborne viral illnesses. We are deeply invested in the success of prevention and treatment efforts in New South Wales. We believe that the primary mechanism that keeps our frontline workers safe—along with the rest of New South Wales—is Australia's human rights-based partnership approach to bloodborne viral illness prevention and treatment. The rate of HIV in Australian people who inject drugs is one of the lowest in the world. Our achievement has been made possible through community engagement and evidence-informed approaches, and is supported by bipartisanship.

The proposed bill is a poor piece of legislation that threatens to undermine our successful response. The bill is not evidence based by allowing testing to occur through including saliva and other bodily fluids that have no risk of transmitting HIV in the definition of bodily fluids. The inclusion of these fluids may increase the anxiety of frontline workers rather than decrease it. The inclusion of saliva also allows for the overuse of police powers, disadvantaging already marginalised people, particularly Aboriginal people, who are disproportionately subject to arrest and incarceration. This bill has the potential to further erode the basic human right of equal access to health care. This bill will increase stigma by promoting the use of misconceptions and stereotypes to direct testing rather than evidence.

Community investment in health works. The partnership approach works with communities to decrease stigma and to increase access to care, as has been noted previously in our highly successful response to COVID-19. If this bill goes ahead we must remove saliva and other bodily fluids where there is no risk of transmission to be tested for blood borne viral illnesses. We must ensure that the decision to test is based in evidence and made by a public health official. The age limit for testing must be increased to 18 and this legislation should not apply to minors. We also need to include a rigorous evaluation process to ensure that it is not over-applied to marginalised groups such as Aboriginal people, people with mental illness or homeless people.

Ms COSTELLO: Positive Life NSW would like to thank this Committee for the opportunity to express the views of people living with HIV in regards to the proposed mandatory testing legislation. Positive Life has been a peer-led and -run representative body of all people living with HIV in New South Wales for over 30 years. We work in partnership with government, business, non-government organisations and research institutes, providing leadership and oversight to the New South Wales HIV response. We acknowledge the importance of maintaining the health and safety of frontline workers and condemn all acts of violence against them.

We join the majority of stakeholder submissions to this inquiry in opposing the mandatory testing legislation as it is not evidence based or grounded in a public health response and lacks judicial oversight. The bill introduced into Parliament requires significant further work. We commend the Standing Committee on Law and Justice on its diligent investigations of the potential harms that will be created by the bill in this current form, and in making thorough amendments before its passage through Parliament and into law. The bill as it stands infringes on the human rights of New South Wales citizens and will exacerbate stigma experienced by people living with a bloodborne virus. Furthermore, there is no evidence that supports mandatory disease testing reducing the fear and anxiety of frontline workers.

Professor GRULICH: I will make my statement about my expertise in transmission. I am here basically in support of Positive Life NSW today, but I just wanted to say a little bit about my expertise and how it relates to the matters under consideration. In my position I lead HIV transmission research at the Kirby Institute at the University of NSW, which is Australia's leading research institute on HIV transmission. I am a past president of

the Australasian Society for HIV Medicine and I currently sit on the governing council of the International AIDS Society, which is the global governing committee for professionals, communities at risk and researchers in HIV. I am a co-author of national and international guidelines on HIV transmission and its relationship to the criminal law. I have appeared as an expert witness in multiple cases of criminal proceedings concerning HIV transmission.

Based on my expertise, I can confidently state that there is zero risk of HIV transmission through spitting whether or not the saliva contains blood. There is zero risk of HIV transmission from bites when the skin is not broken or there is no blood or little blood in the mouth of the attacker. For transmission to be plausible in the case of biting, the HIV-positive person must have blood in their mouth at the time of the bite, the bite must be deep enough to penetrate the HIV-negative person's skin and there must be enough HIV in the person's blood to lead to transmission, meaning that most people who are currently on treatment with undetectable viral load are extremely unlikely to transmit. Even when all of those above conditions are present the possibility of transmission during a single bite is negligible at most; there have been a small handful of cases described in the world.

For all of those reasons I think it is clear to me that the proposed legislation is inconsistent with the scientific evidence on transmission. If applied, I think it would send the wrong message to our police and emergency workers. Potentially through people seeing the need for this legislation it could have the perverse outcome of making them even more anxious about transmission risk, which simply does not exist in most cases. There has never been a case of HIV transmission through spitting or biting in Australia, and this fact should greatly reassure these workers. COVID-19 has been brought up a couple of times in the last 15 minutes that I have been here. That is the most fantastic example of the benefits of evidence-based policy. I think the proposal for mandatory testing is at odds with the science in this field and risks multiple harms, as outlined in the submission of Positive Life NSW and other stakeholders.

Mr COX: Mr Chair, the Sex Workers Outreach Project [SWOP] thanks the Committee for this opportunity to appear and give evidence. We also support our colleagues from ACON and Hepatitis NSW who spoke earlier. I think Professor Grulich has covered the main points of our response as far as epidemiology is concerned. There is no evidence base for this bill. The transmission of the diseases that this bill proposes to test is in fact in most cases virtually impossible. There is no evidence of occupational transmission occurring in Australia, apart from one partially documented case many years ago. Even if transmission were possible, we now have post-exposure prophylaxis—which you have heard about—freely and readily available in all emergency departments for HIV. The prevalence of people living with HIV in New South Wales and Australia is extremely low. We now have approximately 90 per cent of those people living with HIV virally suppressed so that they cannot transmit the virus in any way. HIV, when treated, is now not a fatal disease and does not adversely affect the lifespan or health of persons living with HIV.

Hepatitis B is vaccinatable against. Hepatitis C, as we have heard, is also a disease that is now treatable and no longer chronic or fatal. But what does concern us as sex workers is that this bill could lead to an overuse of police powers. This is an area where sex workers have living memory of legislation that did lead to the overuse of police powers, especially the Disorderly Houses Act, which was amended in 1995. One of the drivers for the amendment of this Act and the subsequent decriminalisation of sex work was the police corruption that was elicited by the Wood royal commission in their report that was presented to this Parliament in the early 1990s.

This legislation has also been used in other jurisdictions and has proved problematic. That was outlined by the previous speakers. A point I would like to make is that, of the 497 persons that Dr Medland mentioned as being tested in Western Australia, over 90 per cent of those people were Indigenous people. These bills tend to be used against marginalised people. And extrajudicial punishment is a road to corruption. Stigma is also something that our community is gravely concerned about. Even though we have a very low prevalence of HIV in our community and the transmission of HIV and other bloodborne viruses in sex work is virtually non-existent and has been since the epidemic started, we are greatly concerned about the stigma against people who may be living with bloodborne viruses that this puts into legislation. I thank you for your time.

The CHAIR: Thank you very much for those opening statements. We will open to questions now. Mr Shoebridge and then Mr Khan.

Mr DAVID SHOEBRIDGE: Thank you all for your evidence today and your work throughout the community. I think all of us appreciate it. Professor, you gave your evidence in relation to the transmission of HIV. That was unambiguous about saliva and the zero risk of transmission through saliva. There is a definition, though, of "bodily fluids" in the bill. What do you understand that might encompass?

Professor GRULICH: It encompasses fluids which may and may not transmit HIV. That is a real problem because HIV, clearly, can be transmitted through contact with blood and through semen. There is no evidence that HIV can be transmitted through saliva. So it is a mixed concept, which requires separation.

Mr DAVID SHOEBRIDGE: If the bill was to proceed, excluding saliva would be an obvious starting point.

Professor GRULICH: Absolutely—a very obvious, very evidence-based step to take.

Mr DAVID SHOEBRIDGE: You give your evidence and your expertise is founded in the study of HIV and the transmission of HIV. Can you shed any light on hepatitis B and hepatitis C?

Professor GRULICH: My expertise is mostly in HIV, but I have worked in both of those fields as well. Both hepatitis B and hepatitis C in general are more transmissible through blood than is HIV. Hepatitis B and hepatitis C cannot be transmitted through saliva.

Mr DAVID SHOEBRIDGE: So excluding saliva from the operation of the bill should apply across the board.

Professor GRULICH: Absolutely, yes.

Mr DAVID SHOEBRIDGE: There is a regulation-making power to add in other bloodborne diseases.

The Hon. SHAYNE MALLARD: As they come along.

Mr DAVID SHOEBRIDGE: As they come along. Is there any positive policy position to include the testing of saliva for bloodborne viruses as—

The Hon. TREVOR KHAN: Can we just have a definition? This is where I was going. What is a bloodborne virus?

Mr DAVID SHOEBRIDGE: Yes. Perhaps I have jumped the gun.

The Hon. TREVOR KHAN: No, I am not being critical. But it seems to me that is where you start.

Professor GRULICH: In common terminology, a bloodborne virus is a virus that can be transmitted through contact with blood. Not all viruses but the great majority of viruses at some stage in their life cycle are present in the blood. But in common usage it means a virus that is transmissible through contact with blood.

The Hon. SHAYNE MALLARD: Blood-to-blood contact or just contact with blood?

Professor GRULICH: That is another question. The blood is a potential vector for transmission. The question of what is then required from the recipient is a different question.

The Hon. SCOTT FARLOW: Just on that point, you said, "That is another question." Do you want to go into that a little bit further in terms of other possibilities there, apart from blood-to-blood?

Professor GRULICH: What I was referring to is that there are two partners in a transmission pair: There is the positive person whose virus might be in the blood and there is where it lands. If it lands on intact skin, it cannot lead to transmission through any of these viruses. But if it lands on an open wound and the blood contains virus then it can potentially lead to transmission for any of those three viruses. It is a pair.

The Hon. TREVOR KHAN: I am interested in what that regulating power means. Would you describe the common STIs as bloodborne viruses?

Professor GRULICH: Not apart from the ones we have talked about today. That is HIV. Hepatitis B can be sexually transmitted as well and hepatitis C is not commonly sexually transmitted but it can be sexually transmitted.

The Hon. TREVOR KHAN: What about COVID? Would you describe that as a bloodborne virus?

Professor GRULICH: COVID can be found in the blood in people with extremely advanced disease but it is not, in the common parlance, a bloodborne virus. Common parlance means that it is transmitted through blood and—

The Hon. TREVOR KHAN: I am sorry to talk over the top, but are you able to give us examples of other bloodborne viruses that could be caught by the regulation-making power?

Professor GRULICH: It would need to very, very clearly define what "bloodborne" means because, as I mentioned, most viruses in their life cycle are present in the bloodstream, albeit transitorily or sometimes intermittently. For example, herpes is an intermittent sexually transmitted infection which can recur during your lifetime. It is mostly present in the spine and in the lesion, which is usually on the genitals or in the mouth. That is its most common places. But those genitals contain blood and therefore some of the virus gets in the blood. It is transitory; it is not there for a long time. So one would have to be extremely specific in a definition. Herpes is

a good example. It is not present in blood very often. To my knowledge there has never been a case of herpes transmitted through blood.

The Hon. TREVOR KHAN: Sorry, David. I cut you off.

Mr DAVID SHOEBRIDGE: No, I think that addressed that issue for me so I am happy to hand over to somebody else.

The Hon. SHAYNE MALLARD: Just following up on that interesting discussion in terms of the regulatory powers, if we were to go forward with those regulatory powers, not knowing what the exact definition is, it would make sense to say "in consultation with the chief medical officer" or "experts in the field" or something like that.

Professor GRULICH: Can I just clarify that the regulatory power you are talking about is the power to add other diseases?

The Hon. SHAYNE MALLARD: To add other diseases.

Professor GRULICH: It would absolutely make sense. Somebody like the Chief Health Officer, the most senior health scientific officer we have, should be involved in that sort of discussion.

Mr DAVID SHOEBRIDGE: I have another question. At the back of the bill there is this schedule or the table. There is a list of at least eight different individuals who are proposed to make decisions, and then each of those delegate to more junior officers to make decisions. In terms of decision-making and assessing risk and balancing things up, if it is going to proceed, some suggest that it should be in the courts, some suggest that this list of individuals and officers is appropriate and some suggest it should be with the chief medical officer and a very senior delegate from the chief medical officer. Do any of you have a view about where the decision-making should lie?

Dr HARROD: Absolutely with the Chief Health Officer or a delegate, yes. That is where the expertise lies to make these decisions. They are health care decisions; they are medical decisions. I think that that office has the capacity to take into account any anxiety, be it increased or decreased by testing, as well.

Mr COX: SWOP would definitely support NUAA in that view.

Ms COSTELLO: As would Positive Life.

The CHAIR: Mr D'Adam had some questions.

The Hon. ANTHONY D'ADAM: I just had a couple of questions. One was to Professor Grulich in relation to whether you have any information that you can provide to the Committee about work-based transmission of hepatitis B or hepatitis C. Is there any data source that you could point us to that indicates, in the past five or 10 years, how many work-based transmissions of hepatitis B or hepatitis C have occurred?

Professor GRULICH: I would say that HIV transmission is my expertise, but there is plenty of data out there on transmission in the workplace settings of those two viruses. Of course, the risk of transmission of hepatitis B is reduced to zero if the person is vaccinated and that is our primary response to preventing hepatitis B transmission in the workplace setting. Hepatitis C is quite transmissible through blood-to-blood contact and so therefore, again, requires a person to bleed into another wound—not on a skin, not on intact skin. Beyond that I really should not talk to hepatitis C transmission.

The Hon. ANTHONY D'ADAM: The other question I had was just about the education of risks. We have heard from a number of stakeholders earlier in the day who are advocates for the bill. I was curious about whether you were aware of any attempts by either police or Corrective Services to engage any of your organisations around educating their staff around the relevant risks—the actual risks—as opposed to the sort of uninformed understandings of the workforce that might exist. Has there been any outreach to your organisations from Corrective Services or police that you are aware of around education?

Mr COX: Not to our organisation, though we do do training with police on sensitivity matters.

Ms COSTELLO: We have not either, but we do have a Positive Speakers Bureau where we go and talk to organisations and schools, and we educate about HIV with the wider community. So there is certainly that option. We are very proactive in that respect and we would love that opportunity.

Mr FRASER: In the number of years I have been with the organisation, the answer is no. They have not engaged us.

Mr COX: Could I also speak to occupational risk, which was mentioned earlier? Sex workers work with an occupational risk of these bloodborne viruses constantly. Through a well-educated workforce, which knows

the risk, is able to assess the risk and use PPE to properly avoid risk, we have virtually eliminated HIV transmission, hepatitis C and hepatitis B from the sex industry in this State.

The Hon. TREVOR KHAN: Does anyone on the panel know what screening for bloodborne diseases is done of prisoners going into custody?

Dr HARROD: I just want to answer the previous question. We have not been approached by police but we have a very strong partnership with Corrective Services in producing a magazine for people who are in prison that talks particularly about hepatitis C treatment and transmission risks. As far as I know, there is not full testing. The Kirby Institute does do a survey every three years assessing prisoner transmission, what prisoners' serological state is when they enter, but not every prisoner is tested when they enter a prison.

The Hon. TREVOR KHAN: Putting aside the mandatory nature of it, would it be appropriate that persons going into custody, both adult and youth, be at least invited to be tested, so that an appropriate treatment regime can be started? If you are not tested, you are not going to get off square one, are you?

Dr HARROD: One hundred per cent, we would support that. I think there is an issue with resourcing of Justice Health and that kind of testing. But, in our minds, everyone who is going into a custodial setting, who is there for an appropriate period of time—that is the other factor that comes into play here. People come in and out of custody, they can be moved with no notice whatsoever or released depending on what happens with their sentencing process, so that is the caveat around it. If someone is coming in for a longer term then, yes—tested, followed up, offered treatment. That would be ideal.

The Hon. TREVOR KHAN: I accept that but, taking into account that people pop in and out of the system, even if treatment has not started, the medical record of the inmate remains. If you have been tested and found to have a viral load, no doubt it is a good place to start a discussion when you come back into custody, I would have thought.

Dr HARROD: Yes. I think you would have to be retested, though. People do acquire hepatitis C in prison with reasonable frequency.

The CHAIR: Could I just inquire, Dr Harrod, you said earlier that you thought there might have been a funding issue with Justice Health. Is that something that you have been told anecdotally or something that has been put to you by persons?

Dr HARROD: It is based on my observation and my experience of my working relationship with Justice Health. I know a little bit more specifically about how offering opioid replacement therapy in prison is challenging because there is a lack of appropriately qualified people to go in and do the treatment with people.

The Hon. TREVOR KHAN: But that is a bit different from testing. We are doing 10,000 COVID tests a day at the moment.

Dr HARROD: Yes, I take that point.

The CHAIR: Yes, that was my point. It was almost like an offhand statement but obviously we are taking evidence here and I just wanted to give you the opportunity to clarify because, to me, it seemed it was incongruous with what we are currently doing around testing and I just wanted some further diving into that.

Dr HARROD: Can I take that on notice then?

The CHAIR: Thank you.

The Hon. SHAYNE MALLARD: I do not know if anyone has the expertise to shed light on it, but we asked a question before: This bill covers a youth group, 14 to 18. I understand—and I asked the hepatitis council representative earlier today—that the juvenile justice system does actually intervene with that age group and make sure they have a hepatitis B vaccination. Mr Shoebridge and I visited juvenile settings and saw very good medical support for them. Is there an increased risk from that age group to prison officers or justice workers for bloodborne diseases, like HIV? The prevalence of HIV in that age group is incredibly low, I believe.

Professor GRULICH: I can speak to the prevalence. The prevalence is vanishingly low in 14- to 18-year-olds in Australia. We no longer have almost any mother-to-child transmission and then adult transmission, we get a case or two a year in 17- and 18-year-olds. It is very, very low numbers.

Mr DAVID SHOEBRIDGE: Can you provide any light on hepatitis C and hepatitis B, Professor, for under-18-year-olds?

Professor GRULICH: Under-18-year-olds now, if they have been born in Australia, will be vaccinated against hepatitis B. Universal infant vaccination began in Australia for hepatitis B roughly, depending on the State, around the turn of the century. They are all vaccinated now, so that will not be an issue.

The Hon. TREVOR KHAN: Is it not terrible that when you say turn of the century, I think 1900.

Professor GRULICH: Indeed.

Mr DAVID SHOEBRIDGE: We are talking the internet; not ironclads.

Professor GRULICH: And hepatitis C, being an infection spread mostly through injecting drug use in this country, is not common at all in people in Australia. It is very uncommon in Australia.

Mr DAVID SHOEBRIDGE: The PSA have raised concerns about assaults and spitting, in particular, in juvenile justice settings. In terms of the three diseases that are in the bill—HIV, hepatitis C and hepatitis B—would it be fair to describe the risks as being "vanishingly small"—that was the language you used.

Professor GRULICH: Absolutely vanishingly small for each of those. It does not make it any less distressing and horrifying to be spat upon, of course.

The Hon. SHAYNE MALLARD: But to take saliva out of the bill sends a message to the frontline workers that medical evidence is that this is not a risk. And if you leave it in the bill, it creates anxiety levels.

Professor GRULICH: Absolutely. It sends them a really important message. If our workers were properly educated then in those settings of spitting—even blood containing spit spat upon the skin—is not an issue. In those settings you could say, "You don't need to worry about that."

The Hon. TREVOR KHAN: What about urine? Because that was referred to in some of the evidence as well.

Mr DAVID SHOEBRIDGE: Urine and faeces.

The Hon. TREVOR KHAN: I was going to get to faeces separately because I think there is a definitional problem with describing faeces as a bodily fluid.

Professor GRULICH: That is very simple to answer. No, transmission does not occur through those two fluids.

The Hon. TREVOR KHAN: Right. Of all those viruses.

Professor GRULICH: Of all those viruses.

The CHAIR: I thank the witnesses for appearing. For the questions that have been taken on notice, the Committee has resolved that answers will be returned within 14 days. The secretariat will contact you in relation to the questions you have taken on notice.

(The witnesses withdrew.)

(Luncheon adjournment)

KYLIE VALENTINE, Deputy Director, Social Policy Research Centre, UNSW, affirmed and examined

MARTIN HOLT, Research Convenor, Centre for Social Research in Health, UNSW Sydney, affirmed and examined

KARI LANCASTER, Scientia Senior Research Fellow, Centre for Social Research in Health, UNSW Sydney, affirmed and examined

DANIELLE McMULLEN, President, Australian Medical Association (NSW), before the Committee via videoconference, affirmed and examined

The CHAIR: Would anybody like to start by making a short opening statement? If so, please keep it to no more than a couple of minutes.

Professor VALENTINE: In the interests of time and not recapitulating things that have already been said, I will draw attention to only a few points in our submission that have come up in conversation this morning. One of them is the definition of "deliberate," which I think Mr Shoebridge was asking about this morning. We have detailed in our submission the problems with the wording of the bill as it is currently drafted, precisely because of the vagaries of the word "deliberate" and how it is used and the risks that it could put our frontline workers, who the bill is meant to protect, under by subjecting them to a legal process that is shaky and not robust. So rather than going through the machinations of the wording and the problems with it, I just draw your attention to it.

The second thing that I would draw attention to is the point that was made this morning about blood being weaponised as a kind of key object of the bill. We would point out in our submission, as other submissions have made, that if the purpose of the bill is to alleviate the anxiety and stress on frontline workers, then a bill that confirms that blood is a weapon, and that people should be frightened if they have exposure to it, goes against all of the national health guidelines and the way that the treatment landscape has changed and is more likely to exacerbate the stress and tensions faced by the people who the bill is meant to protect than to relieve it. Other than that, I would just reiterate that we have heard a lot this morning about the unnecessary and worrying aspects of the bill that it does not balance the rights and interests of all of the parties affected; there is no public policy justification for it; it does not solve any problems that the current system has; and it is more likely to raise new problems than to solve them. Thank you.

Professor HOLT: Similarly, I prepared a statement and I will shorten it because I know you have been hearing from a lot of people. You will see from our submission that we oppose the bill in a similar way because we think it is unnecessary and poorly defined. We are also quite seriously concerned about unintended consequences of the bill. In particular, we recognise that frontline workers do essential work and deserve safe and respectful work environments, but we see nothing in the bill that would make their work safer either for them or for the people they interact with. As others have noted in their submissions, most of the incidents that are described in the bill pose no risk of transmission and therefore we are worried that the bill mistakenly implies there is significant risk in all of these incidents. We actually think one of the things that may be a perverse consequence of the bill is that it will signal to frontline workers that there is substantial risk in many situations when there is none, and that is one of the key things that we are worried about.

Seconding what my colleague from the university also says, as part of the partnership response to bloodborne viruses in New South Wales over decades, which is a rights-based response, we think that the bill denies rights, particularly to people who frontline workers work with, and the principle of voluntary and informed testing. But perhaps more dramatically, which other have already noted, it relies on outdated and fearful beliefs about bloodborne viruses in a situation where there have been substantial improvements in prevention, testing and care, and we think that some of these fears and outdated beliefs should be tackled instead.

The CHAIR: Your opening statement, Dr Lancaster, was linked with Professor Holt's?

Dr LANCASTER: Yes, on behalf of both of us and the centre's submission.

The CHAIR: Thank you. Dr McMullen, would you care to make an opening statement?

Dr McMULLEN: Thank you, and I will also keep it brief. The Australian Medical Association [AMA] of New South Wales does not support the Mandatory Disease Testing Bill, and while we acknowledge the seriousness of bloodborne viruses and obviously the concern that emergency workers have about their risk, we would say that the distress that they're feeling would not be alleviated by mandatory disease testing. As we have outlined in our submission, we will highlight a couple of points that the baseline level of the risk of transmission of bloodborne viruses in the settings as described through the bill—including hep B, hep C and HIV—is very low.

For example, the risk of transmission of HIV from mucous membranes or broken skin is less than one in a thousand, and often in other scenarios is negligible, as others have said, and so close to zero we would call it zero.

In circumstances where there has been a potential exposure, emergency personnel are advised to follow bloodborne virus exposure management protocols, which include first aid and medical review and there are clear guidelines around how to do this. Testing of the source person and whether that be mandatory or voluntary does not alter the initial management of a bloodborne virus exposure. If a significant exposure has happened there is obviously first aid to be done and it is critical that clinical assessment takes place quickly, within that 72-hour type time frame, to assess whether post-exposure prophylaxis for HIV risk is required. But those guidelines clearly state that the HIV status of the source case does not need to be known and testing should not delay treatment. Furthermore, from a clinical perspective, HIV and other bloodborne viruses have a window period where infection may not be detectable in the source case but could be, theoretically, transmissible. That is another reason that testing the source case clinically does not change the management or the outcome for the affected worker.

We strongly support emergency services workers having access to urgent assessment, counselling and management by a healthcare professional after exposures. However, given the process outlined in the bill, which could take up to three weeks, it is unlikely that legislation would aid in any prompt evidence-based management. Mandatory testing, furthermore, reduces a person's autonomy to consent to medical procedures over their own health information and contributes to the stigma and discrimination of people living with HIV, hepatitis B and C, so we are concerned that that would further limit access to medical care for people with those diseases.

In the bill there is also comment about mandatory testing for people 14 years and older. We take particular concern with the mandatory testing of people under the age of 18. Again the risk of these young people carrying infection is very low. We do not think they should be subjected to mandatory and invasive medical testing. We are also concerned about the use of force that might be required by police or corrections officers in order to undertake mandatory testing and the potential safety risks that that would have for the personnel involved. In summary we would conclude that the benefits of mandatory testing to emergency services are very low and certainly do not outweigh the impact on the rights of the source person to consent to medical tests.

The CHAIR: Thank you very much. I will now open up to questions.

The Hon. ROD ROBERTS: Dr McMullen, is it all possible, not in all cases but in some cases, that blood can be present in both urine and faeces?

Dr McMULLEN: It is possible; it would not be normal. That would be a pathological process. That person would need medical assessment as to why it was happening.

The Hon. ROD ROBERTS: Certainly an indication of something more serious, I would imagine.

Dr McMULLEN: There should not be blood cells in urine or faeces. However, that would not change things. Even if there was blood present in urine or faeces, exposure to that generally would not pose a high risk of transmission of illness, much like exposure to blood. If you have closed skin then the risk of contracting an illness from exposure even to blood is negligible or zero.

The Hon. ROD ROBERTS: But in conclusion it is possible, on rare occasions, that urine and faeces could contain blood.

Dr McMULLEN: Yes, but that would not cause an increased risk of infection of bloodborne virus.

The CHAIR: This is probably to you, Dr McMullen, and also to you, Professor Valentine. Both of your opening statements made reference to the rights of people to reject invasive testing. I guess I am looking at this from a standpoint of where an individual has used their secretions as a threatening weapon, whether it be transmittable or not through saliva. Have they not reduced their rights to reject invasive testing, where they have imposed their fluids on another? Do you understand where I am going with this? Has their act of aggression or attack perhaps ameliorated their rights with regard to invasive testing? I would be curious to know the AMA position on that and also yours, Professor valentine, in your research.

Dr McMULLEN: Our primary point is that, regardless of the result, the management for the affected staff member is unchanged. Our primary argument is that whether or not you can test the source person does not change the treatment of the affected worker. However, we also note that people may be aggressive for a number of reasons. Sometimes that is because they are affected by drugs or alcohol. They may have mental health issues. They may have an organic medical problem where they do not have control of their behaviours and faculties at the time that they have done the offending behaviour. There are a number of reasons people may be aggressive. We do not think that in those cases forcing them to have a test would be ethical. Again, as I highlighted before, the issue of subjecting people to mandatory testing may in fact pose further safety risks to staff involved rather

than fewer safety risks. They are a few of the reasons that we think that mandatory testing does not make sense. Hopefully that answers your question.

Professor VALENTINE: I would absolutely reiterate the points made by Dr McMullen. From the point of view of proportionality, there is a strong imperative for medical consent to be obtained unless there is a really, really good reason for there not to be. In this case there are not any policy or health grounds for overriding that consent. To your point of whether or not people veto their rights by doing a particular task, I am not a lawyer—I do not know whether you are.

The CHAIR: Certainly not.

Professor VALENTINE: If I am a nurse taking blood tests, I am probably not a lawyer either and it should not be my responsibility to adjudicate the standing in terms of human rights of the person who I am dealing with. The point about the aggression and potential violence to which frontline workers are subjected, I think, has been made several times this morning. If the testing is being used as a strategy or tactic then, as the point has been made, forcing it is not likely to mitigate the risks of that.

The CHAIR: The reason I asked the question was this morning we heard quite a bit of evidence from stakeholders in particular that, while the exposure to disease is an issue, largely the issue is around the mental health of the person affected. So while I accept that medically and from other standpoints there is perhaps not the level of risk that is perceived with the members who have received either injury or attack, knowing that the person does not carry the bloodborne diseases that will be tested will provide a level of reassurance and reduce the anxiety of that person. That is why I was curious to ask both of you who made reference to the rights of people not to have invasive testing whether that right, in your opinion, given that you referenced those rights, was more important than people having the reassurance. I think that is the balance that—

Professor VALENTINE: To that we would say that people also have a right to not be taking blood from somebody who does not want to be giving blood and that that level of reassurance is also a workplace right. We would also reiterate the point that has been made this morning several times already that if people are feeling anxious about exposure when that risk is not real, the responsibility of the workplace and the institution is to provide better counselling, support and advice on the risk to which they are actually exposed. Because there has been absolute consensus on the window period, which would mean that the test does not actually alleviate that hypothetical distress anyway.

The Hon. SHAYNE MALLARD: All the medical evidence that has been given today, all the submissions we have had from medical professionals, is that saliva is not a transmitter of the virus and that in fact, basically, blood is. Under the scenario the Chair has put forward, for the peace of mind of the worker you are forcing blood tests on the basis of saliva, we are moving into an area of medical intervention that is punitive. As medical professionals, the AMA in particular, would you find that problematic?

Professor HOLT: I am not a medical professional, but, yes, as a researcher in the area, absolutely. One of the things that struck me, reading the bill, is there is a huge range of potential scenarios included here. Some of the submissions describe clearly quite distressing aggressive situations where there is no risk of transmission—it is just not plausible or feasible. There are no documented cases, particularly with saliva. Vomit and faeces have been mentioned. Really there is such a narrow range of situations where there is a potential risk, blood to blood. Even in some of the situations, as Dr McMullen has described, where there is blood present, if there is no breaching of the body, there is no risk of transmission. I made in my opening statement a truncated point about this potential for unintended consequences. The bill sends to frontline workers the message, "Yes, we've got what we want. We can test lots of people," but it actually sends, I think, a pernicious message that the risk of transmission is much, much higher than it has ever been proven to be. In fact, it is almost nothing.

The Hon. SHAYNE MALLARD: Dr McMullen, on behalf of the AMA, what is your position on the notion that we are moving into a punitive use of medical intervention?

Dr McMULLEN: Certainly we would not be in favour of forced medical testing when there was no clinical benefit to either the person being tested or the person who had been affected by the behaviour. From a medical perspective, it makes no sense to do the test on a mandatory basis.

Mr DAVID SHOEBRIDGE: Thank you all for your submissions and evidence. We heard from the Police Association and the PSA. They made assertions that, if a frontline worker is spat upon, and then if a test is done, and if it comes back negative, that will assist them dealing with trauma and assist their psychological response to the incident. Are you aware of any studies or any evidence that supports that hypothesis?

Dr LANCASTER: To our knowledge, we are not aware of any studies that support that hypothesis, but I think I would reiterate what Professor valentine said before as well and what has been said this morning. Any

reassurance that comes from that test is based on very outdated assumptions about bloodborne virus transmission and the risk to those workers. It is much more important, at this point, to educate the public and frontline workers around bloodborne virus risk transmission, but also about the era that we are in, in terms of an era of viral elimination and the potential of new prevention and treatment technologies, which make viruses like hepatitis C curable with highly effective treatment, very short periods of treatment and with minimal side effects. So we are not talking about the same viruses in some ways that we were talking about maybe 30 years ago, in terms of the effects that they may actually have in people's lives, under the very, very slight circumstance that there may have been an exposure to risk. As Dr McMullen and other medical professionals have said this morning as well, the medical advice probably would not change in terms of the advice given to the frontline worker if there was a medical assessment of exposure under very particular conditions.

Mr DAVID SHOEBRIDGE: Given the now unanimous medical evidence that we have had that there is zero risk of transmission of these bloodborne diseases through saliva, and given also, if we accept the PSA's evidence, that about 20 per cent of the prison population may have hepatitis C, might not the testing actually produce the very worst outcome in at least one in five cases in the prison system? The test may come back and say "positive for hepatitis C" and greatly raise the concerns of the worker who was spat upon, even though all of the medical evidence says there remains no risk. It may actually have a very perverse and negative outcome.

Dr LANCASTER: Again, it is a very shifting environment in light of the treatments that are available for hepatitis C. There have been some very large studies done in New South Wales prisons and also in the community recently which have shown the success of treatment rollout amongst prison populations and including attempts to create elimination within particular prisons and within particular populations.

Mr DAVID SHOEBRIDGE: Which has been successful in a number of prisons.

Dr LANCASTER: Which has been hugely successful, so it is a very rapidly moving landscape and there are huge investments and great policy efforts at a national level and also a State level to move towards elimination. I think, as has been said already by my colleagues, a bill like this serves to entrench outdated assumptions rather than creating a workplace that responds to a rapidly moving viral elimination context.

Mr DAVID SHOEBRIDGE: Even without a study to support it, you can see a scenario where, if a frontline worker is spat upon and then society and their workplace considers that such a serious issue, in terms of potential bloodborne viruses, that a process of compulsory testing follows, surely that is exactly the wrong message to send in those circumstances and could only lead to increased irrational anxiety and trauma on behalf of those workers?

Professor HOLT: I was just going to take your hypothetical which is, of course, that any positive result in that scenario, where there is no risk of transmission, is going to concern the worker—not to mention the person who has had compulsory testing if they do not know their status, who actually is probably the priority in terms of health outcomes here—because the frontline worker is at no risk, for example, of hepatitis C transmission through saliva.

Dr LANCASTER: It is a potential lost opportunity to engage that person in treatment as well. If testing is done under conditions that are punitive, that are not under conditions of consent, then it would be very difficult to engage someone who has been given a positive test.

Mr DAVID SHOEBRIDGE: "Come back again in a week for your treatment after we have just tied you down and forcibly removed a sample from you." That is not a positive scenario.

Dr LANCASTER: Absolutely. It is contrary to all of the partnership approach and messaging that is going on in terms of the strategy to eliminate hepatitis C in New South Wales, Australia and indeed the world by 2030.

Professor HOLT: I just wanted to pick up part of our submission about trying to tackle stigma and discrimination, which New South Wales as a State has committed to. One of the problems in these scenarios, where people are diagnosed in circumstances that they did not anticipate, is we actually have effective treatments and cures for some of these conditions, but it is actually retaining people in care or getting them to engage in healthcare. If we are talking about these scenarios in a voluntary situation, you may be able to say, "This is fine; we can treat you." In a hostile and antagonistic situation as this, persuading someone that they could actually have hepatitis C cured, for example, is that much more challenging. It is actually undoing some of the goals that New South Wales has subscribed to for probably over a decade.

The CHAIR: That is almost the perfect lead-in to what I was going to seek clarification on, which is: Certainly the way that you have framed a lot of these answers is that the individual who is the subject of the testing is, I guess, rational and that you are able to have a rational conversation with them around receiving treatment,

should they have a positive test. You are saying that that would be adversely affected if they were forcibly tested and become distrusting of the medical services. But, in the instance where they have performed a deliberate act, is it not unlikely that they are probably slightly irrational anyway and that talking about rationality and receiving treatment is probably incongruous to the fact that they are in this position in the first place? I am just seeking your thoughts on this because it is the first thing that comes to my mind when you talk in those terms.

Professor HOLT: To clarify my point, I was saying I am agreeing on some level. We do not really want someone undergoing testing and receiving a diagnosis in this circumstance. We actually want people to volunteer for testing at a time that they are ready to receive their result. This is exactly the wrong circumstance to subject people to testing and find out about their health status. Certainly, there are good examples in correctional settings where actually, given the right environment, people willingly come forward to find out their hepatitis C status. But we do not force it upon people.

Professor VALENTINE: I have a slightly different response, which goes to some of the discussion again on the definitions of "deliberate" that were being discussed this morning. It is not in our submission, but it was highlighted this morning that the people who have been subject to the most mandatory testing in other jurisdictions are those people who are most in contact with correctives and police, including people with disability, and Aboriginal and Torres Strait Islander people. Every time there was a question about a definition of "deliberate", the response was always an example, and "I know it when I see it" was the tenor of discussions about "deliberate". If somebody is working with somebody with an acquired brain injury or a cognitive impairment, that assessment of "deliberate" as opposed to "not deliberate" is going to be a lot more tricky in the circumstance and also a lot more vulnerable to legal challenge. To the question of whether or not somebody is rational or not, that again is a hypothetical question that was very much the sort of flavour of the discussions this morning—a hypothetical aggressive person using their blood as a weapon. So the public health message is very strong, as the AMA submission and my colleagues have said, that the environment should not be subject to the whim or the happenstance of people's state of mind.

The CHAIR: I accept that. Mr D'Adam, do you have a question?

The Hon. ANTHONY D'ADAM: It seems that the proponents of the bill are really motivated by this question of allaying the concerns of the worker who has had workplace exposure. It strikes me that the primary risk in this situation is actually one of psychological harm, and that that is actually caused by what you have described as outdated attitudes. What would a program look like that might address the issue around possible psychological harm as opposed to trying to address it through mandatory testing? The primary concern seems to be driven by police officers and those working in our correctional system.

Professor VALENTINE: I think the AMA submission details very beautifully the kind of support that should be in place for workers, whether or not they are subject to that psychological harm but as a matter of course. We also heard the PSA this morning. The idea that people feel that they cannot hug their kids for three months or that they need to eat off separate crockery is enormously distressing. If that is the case, and if it is the case that people do not have good information on transmission but they do have good information on PTSD acquired from being spat on, they are not being supported by their workplace properly and given the information that is accurate and should alleviate their distress.

The Hon. SHAYNE MALLARD: It is from the 1990s.

Professor VALENTINE: There is no way that anybody could support a situation where a frontline worker was so distressed for such a long time, and there is absolutely no reason for it.

Mr DAVID SHOEBRIDGE: Dr McMullen, from a treatment point of view can you see a scenario in which a frontline worker would be given that direction to eat off separate crockery, to not hug their children for three months following one of these kinds of incidents?

Dr McMULLEN: Unfortunately, I can't say that it has not happened. That is not the up-to-date medical advice. We would encourage people who have been affected to live their normal lives. We would be in favour of counselling being made available to these people because obviously being attacked in any form is distressing in and of itself. So people may need counselling both around the trauma of the attack itself and through the risk or lack thereof of a blood-borne virus transmission. But in most cases we would not suggest that people should be altering their way of life in terms of, you know, sharing towels and crockery and things, and hugging their kids for the next three months. It should not be that traumatising a process.

Again, as others have mentioned today, it has been an evolving landscape over the past 10 to 20 years. So there is incorrect information out there and we need to do what we can to correct it. If that included, for example, an education program throughout police and other emergency services training, where health advice was given about the baseline prevalence of blood-borne viruses and those of transmission, and the lack of risk in some

of their occupational-type exposures even where there has been aggressive use of bodily fluids, we would be supportive of education programs. We are also supportive of being able to provide medical help and support as well as counselling help and support at the time of incidences and think that that should be resourced appropriately.

The CHAIR: Dr McMullen, can I just ask one final question? I understand the position that the AMA has adopted, which you presented today, that there is very little risk of transmission in many of the circumstances which have been presented to the Committee throughout this morning and indeed this afternoon. However, with all of that, does not the person who has been attacked have the right to reassure themselves that the person who has attacked them does not carry, or will have a risk of transmitting, a blood-borne disease or virus? Does that person not have an innate right, from a medical standpoint, as well? I guess that is one of those philosophical questions I am grappling with around this. A person has been attacked. Whether it is right or wrong medically that they may have a very small risk of transmission, they may be reassured to know that the person who has attacked them does not have a blood-borne virus that is posing a potential risk to them. Medically, does that patient not have a right to that psychological benefit?

Dr McMULLEN: It would not change things.

The CHAIR: I accept that it would not change—

Dr McMULLEN: If we did not already know the status—it cannot reassure them; it should not reassure them. A negative test on that day could theoretically be within the window period of infection of the person who had done the attack. So even a negative test that day does not change our risk metric. I understand the psychological distress. As healthcare professionals we also have bodily fluid exposures and often do not know the status of the person whose bodily fluids we have been exposed to. And as a GP I have seen people in this scenario. It is a distressing time for everyone and it takes time to talk through with people their fears about it and what it means for them. That may be a number of consultations.

If we already know the status of the attacker, so to speak—I do not like the language but that is what we are using—that may adjust treatment. But if we do not already know the status of that person—and that is particularly to do with HIV status—if we do not already know their HIV status, then it does not change the management protocol or what treatment they should be given. And a test that is done even that day would not address their psychological discomfort because they would still need to be a little bit worried. It is not all over until that six-month test is done and it is over. So it would not change the psychological thing. Also under the bill it may take up to three weeks for the mandatory test to be done. Certainly by that stage we have hopefully counselled them through their psychological distress and it would not change things at that stage.

The Hon. SCOTT FARLOW: Dr McMullen, I am wondering whether the AMA's position on the concerns you have raised with respect to bodily autonomy and the intrusion of blood tests extends to the Road Transport Act provisions for mandatory testing.

Dr McMULLEN: I can take that on notice but my understanding is that we are not raising a current complaint with existing mandatory testing to do with road transport. But we can get back to you.

Mr DAVID SHOEBRIDGE: In doing that, you might want to consider in your answer the nature of the purpose behind the two different regimes.

The Hon. SCOTT FARLOW: You are leading the witness, David.

Mr DAVID SHOEBRIDGE: But it is quite a different thing to test where there is a purpose and to test where there is not.

Dr McMULLEN: The question kind of caught me off guard but, yes, when we are looking at road traffic accidents it is a contributing factor potentially to what has happened, and there are laws in place there. But in this case our strong medical opinion is that testing of the source person does not change the treatment protocol for the affected person.

The Hon. SHAYNE MALLARD: We are talking evidence of a crime versus medical evidence.

The Hon. GREG DONNELLY: AMA, thank you very much for your submission. I will take you to the first page of the your submission, the penultimate paragraph, which makes reference to the other jurisdictions—Western Australia, South Australia, Queensland and Victoria—and goes on to make some comment. Are you able to elucidate on those jurisdictions and the regime that applies there? Or is that just some general information you have received?

Dr McMULLEN: I can take that on notice. We can provide further information if required. At this stage I have that as well.

The Hon. GREG DONNELLY: Put that on notice. Thank you.

Mr DAVID SHOEBRIDGE: If you are doing that, whether or not the Victorian or the Western Australian model, could you provide whatever the respective merits and demerits of those two schemes are, because they are quite different, particularly as to who does the testing?

The Hon. SHAYNE MALLARD: We had some evidence on that this morning.

Dr McMULLEN: We can provide for you what the situation is in those States. But I do not know that I can commit to doing a research project on the merits and demerits. If you need information from those jurisdictions, perhaps maybe from there.

Mr DAVID SHOEBRIDGE: I was not hoping for a research paper; more an opinion was what I was after.

The CHAIR: If Mr Shoebridge has stopped leading the witness and giving the witnesses tasks, we will call a conclusion there. The Committee has resolved that questions taken on notice be returned within 14 days. The secretariat will contact you in relation to questions you have taken on notice.

(The witnesses withdrew.)

(Short adjournment)

ALASTAIR LAWRIE, Senior Policy Officer, Public Interest Advocacy Centre, before the Committee via videoconference, affirmed and examined

JANE SANDERS, Member, Law Society of NSW Criminal Law Committee, affirmed and examined

GABRIELLE BASHIR, Senior Vice-President and Co-Chair of Criminal Law Committee, NSW Bar Association, sworn and examined

The CHAIR: Would anybody like to start by making an opening statement? If so, please keep it to no more than a couple of minutes.

Ms BASHIR: Thank you. On behalf of the New South Wales Bar Association, I acknowledge that we meet on the land of the Gadigal people of the Eora nation and pay my respects to Elders past, present and emerging. The New South Wales Bar Association welcomes the opportunity to appear before the inquiry into the Mandatory Disease Testing Bill, which I will refer to throughout my evidence as "the bill". I give evidence here in my dual capacities that I have just put onto the record. The Bar Association's written submission of 21 December 2020 set out that, while the Association supported the bill's intentions, the Association opposed the bill without the inclusion of the following six safeguards. Firstly, the bill should expressly state that, if alternative measures are available that are equally effective in ensuring rapid diagnosis and clinical management for any specified worker, the measure which is least restrictive of the rights of the third party or vulnerable third party should be chosen. This safeguard is actually included in Victoria's mandatory disease testing scheme under section 134 (11) of the Public Health and Wellbeing Act 2008, and the making of an order is subject to that consideration in Victoria.

Secondly, the definition of "vulnerable third party" should be expanded to reflect the potentially wide application of the bill and should include, for instance, those who identify as Aboriginal or Torres Strait Islanders. We make that submission because those people are in a particular position of overrepresentation in custody and this is aimed at custodial settings. Thirdly, a mechanism for an appeal by a third party or a vulnerable third party against a mandatory testing order should be included in the bill, with decisions made by a senior officer concerning a third party appellable to the Local Court for a de novo hearing and decisions relating to a determination by the Children's Court or the Local Court relating to a vulnerable third party appellable to the District Court, again for a de novo hearing, within a short space of time—the courts are used to urgent applications—and with a view to being heard as soon as possible by the relevant court.

Fourthly, the proposed mandatory testing regime should not apply to children of any age. Currently the bill provides for those between 14 and 18. Fifthly, all blood samples obtained for such mandatory testing ought to be compulsorily destroyed after completion of testing and, we would add, on any review period expiring. And to avoid any potential widening of the use of blood samples, there should be an absolute prohibition on the use of samples in any other type of testing, such as for DNA testing. The Association also recommends additional safeguards to address necessity and proportionality. These are not in our letter. So I do just wish to outline them. The medical practitioner consulted by the worker should be required to certify in writing that the testing of the person whose bodily fluid has come into contact with the prescribed worker is necessary in order to provide medical treatment to the prescribed worker. Such a certificate should be a precondition to an application and the legislation amended accordingly. Section 134 (1) (d) of the Victorian legislation might provide a starting point for consideration of such an amendment. I will come back to that in the course of evidence if necessary.

There should be a reasonable period for a review application rather than the one day that is currently in the Act. That is not sufficient time, for example, to obtain an independent medical opinion. The bill now also specifies that, even where there is an application for review to the Chief Health Officer, the order under review continues to have effect and the third party must comply with the order. This may create a disproportionate imbalance in the Act by negating a protection that should apply, to be free from bodily interference pending the review. The Association is concerned that the bill achieve the legitimate aims of protecting the health and wellbeing of emergency, Corrective and other health workers, without unnecessarily or disproportionately encroaching on the rights of individuals in New South Wales. We have had the opportunity to read the AMA's submission. We are concerned that, without adding at least the safeguards that we have proposed, what is currently enacted may not be reasonably necessary or proportionate to the aims it is seeking to achieve.

The intention behind the bill is, according to the Minister, to "help to reduce some of the stress and anxiety" that emergency services and health workers "may suffer if exposed to the risk of a bloodborne disease". The Bar Association recognises that stress and anxiety for frontline workers and their families because of an actual or perceived risk of exposure to bloodborne diseases such as HIV or hepatitis C. But the necessity and proportionality of the measures are to address such stress and anxiety. In circumstances where the medical evidence—on the assumption that what the AMA has given evidence of is correct—is that the enactment of the

regime would not reduce the risk of infection, that it may divert resources away from prophylactic measures intended to minimise the chances of workers contracting bloodborne diseases, and that by the time the results were received, the worker would be nearing the end of or have completed the course of PEP requirements and treatment, there are clear questions raised as to the bill as currently drafted being a necessary and proportionate measure to protect the health and wellbeing of frontline workers. We say that this underscores the Association's recommendations, in particular those to which I have just referred, for certification from a specialist as to the necessity for the blood sample and also the safeguard as to taking the least invasive option where equally effective measures for rapid diagnosis and management are available, such as exists in the Victorian legislation.

The Victorian legislation also contains safeguards for the use of reasonable force to have a blood sample taken, with exceptional circumstances required to be found first by a court. In Victoria the Chief Health Officer applies for an order. If force is required to take it, there has to be an application to the court and the court, if it finds exceptional circumstances, can sanction the use of such force.

The Association also notes that the proposed scheme would require significant resources to operate. That is clear from the bill itself but also from the submission of the Ombudsman. Simply to monitor the bill will, according to the Ombudsman, require the allocation of additional funding and powers. In circumstances where the bill provides for ordering that an individual should: first, mandatorily and, in some cases, forcibly, have blood taken from an individual; second, have the samples tested; third, have those results divulged to others. They all represent serious encroachments on the privacy and the bodily integrity of those subject to mandatory blood testing.

In relation to that, we also say that, in addition to protections in the bill from disclosure of health information, which is particularly defined, there do not seem to be any protections or uses of the blood sample itself. So while there are nondisclosure requirements, we recommend safeguards including the destruction of the sample following use, as sanctioned by the Act and any appeal periods, and a prohibition on other uses of the sample. While we understand the intentions and purposes of the bill and the important need for protection of the health and wellbeing of our frontline workers, without the inclusion of the safeguards that we recommend, our position is that the legislation does not meet its aim of being reasonably proportionate or necessary to meet its purposes.

The CHAIR: Mr Lawrie, would you now like to make an opening statement on behalf of your organisation?

Mr LAWRIE: Thanks very much for the opportunity to talk here this afternoon to expand upon our concerns about the Mandatory Disease Testing Bill. As noted in our submission, the Public Interest Advocacy Centre [PIAC] believes the bill should be rejected in its entirety. While we acknowledge workers have the right to a safe workplace, the legislation currently before the Committee is not an appropriate way to achieve such an objective. We are not alone in reaching this conclusion. The majority of organisations making submissions to this inquiry oppose this legislation. The views against the bill are perhaps best summed up in the submission by ACON:

> Mandatory Disease Testing does not offer any additional peace of mind to front line workers beyond what would already be available to them through current public health developments. Vaccination programs, post exposure prophylaxis medications, effective anti-retroviral therapies and effective cures which are available to all negate the need for this stigmatising intrusion into the civil liberties of people.

Nevertheless, if Parliament intends to go ahead with the mandatory disease testing regime, we have made additional recommendations to reduce the harm that would be caused by aspects of this bill. I will focus on two particular areas in these introductory remarks. First, as discussed in our submission, we consider that, while the bill is predicated on the idea that mandatory testing orders will only be imposed on third parties whose deliberate actions cause their bodily fluids to come into contact with a relevant worker, this framework is not reflected in the drafting of the bill. Under proposed section 9 (1), the primary evidence of the deliberateness is the worker's own description of the incident and their opinion that the contact with a third party's bodily fluid was a result of deliberate action of the third party. Meanwhile, none of the decision-makers nominated by the bill—senior officers, judges or the Chief Health Officer—are explicitly required to consider whether the exposure to bodily fluids was deliberate; merely whether the order is justified in all the circumstances.

Second, we are concerned about the lack of procedural fairness for third parties. This includes the time lines, or lack thereof, provided to make submissions throughout the decision-making process. For example, while the worker has up to five business days to submit their application for a mandatory testing order, there is no minimum time period for the third party to make a submission. Under section 10, the senior officer must merely provide an opportunity—an unspecified [inaudible]—during the three business days in which they are determining the application. The time provided does not even need to be reasonable. Similarly, under section 22, both workers and third parties have just one business day in which to lodge an application for review, in writing and in the form

prescribed. This time line will be difficult to meet for most third parties and especially for vulnerable groups, including people in custody. Finally, PIAC can see no justification for section 23, which provides that mandatory testing will just continue to have effect during the review period by the Chief Health Officer. I look forward to answering any questions you may have about this issue and about the remainder of PIAC's submission.

Ms SANDERS: The Law Society endorses the comments made by the Bar Association and PIAC. We have similar concerns about the bill. The Law Society's primary position, as we have said in our very short submission, is that the aims of the bill are laudable, but we believe the bill does not achieve the stated aims. I would say it does not even begin to achieve the stated aims, which are to protect and give some comfort to emergency services and healthcare workers. Even if the bill did go some way towards meeting the stated aims, we then have to look at whether the measures in the bill are reasonably proportionate, having regard to the incursions on people's bodily integrity and we, like the Bar, PIAC and many of the other organisations who have made submissions, are of the view that it tips the balance too far and that it is not reasonably proportionate.

New South Wales, over the last 11 to 12 months, has done very well at managing the COVID-19 pandemic by listening to the infectious diseases experts, taking health advice and taking evidence-based measures which do, in some part, involve a restriction on people's movements and imposing mandatory mask-wearing in some contexts, et cetera. But the important point is the way in which our government, not just in New South Wales but in most other Australian jurisdictions as well, have listened to the health experts. The response to COVID-19, unlike perhaps in some other countries where the pandemic is running rampant, has been soundly evidence based. I would urge this Committee, when thinking about its recommendations, and more broadly would urge the Parliament, to again listen to the health experts and look at the evidence. If that is the path that is followed, I would say that any stated justification for the bill, or for the measures that are proposed in the bill, very quickly falls away. The chief supporters of this bill are the NSW Police Force, the Police Association of New South Wales and, to some extent, the ASU, which represents correctional officers and Youth Justice officers.

The Hon. SCOTT FARLOW: The PSA.

Ms SANDERS: The PSA, sorry, not the ASU. The ASU is, of course, strongly opposed to it and the ASU represents a large number of workers in the affected sectors as well. The professional bodies and unions who represent health workers, of course—the AMA, the Australian Salaried Medical Officers Federation and the like—they are all strongly in opposition to the bill. They of course want to see their workers protected. They want to see a minimum of stress and anxiety occasioned to their workers as a result of a needlestick injury or transfer of bodily fluids, but they understand the evidence and they understand that the proposed measures in the legislation really are misplaced. So I would urge everybody to listen to the health experts. I would say that stress and anxiety are very real. I am not meaning to minimise that or trivialise that. There is no doubt that an emergency services or health worker who receives a needlestick injury, or even is spat at, or comes into contact with bodily fluids in some other way, may understandably have considerable anxiety about whether they have picked up a bloodborne disease.

However, many of the submissions from the people who know much better than I do talk about this being based on misplaced anxiety and misplaced confidence. The evidence shows that the risk of transmission of bloodborne diseases from the types of contacts that are contemplated by the bill is relatively low. But most importantly—and other submissions make this very clear—the best way to alleviate people's anxiety and give them comfort is, of course, to use all of the very sound evidence-based health measures, which are in accordance with the NSW Health policy, I might add. They involve counselling and treating the worker; administering post-exposure prophylaxis [PEP] in a timely manner if the risk is seen as necessitating that; providing better personal protective equipment; and, above all, also providing further training and education. I would suggest that perhaps, without any disrespect to the police and the Association that represents them, that particularly police and maybe other emergency workers who are not health workers could benefit from some further education about the actual risk and the actual mechanism of transmission of bloodborne diseases, and also the limitations of testing of the source.

The Hon. SHAYNE MALLARD: I think the whole community could benefit from that.

Ms SANDERS: And the whole community could. The submissions made by the organisations who support this bill emphasise above all else the stress and the anxiety occasioned to the emergency services workers. This is not the way. Just like locking up children is not an evidence-based way to deal with the community's anxiety around crime. Rolling out hydroxycholoroquine or drinking bleach is not an evidence-based way to deal with the community's anxiety about COVID-19. This is not evidence based, and it is unlikely to be an effective way of really managing the stress and anxiety. If the bill is to be enacted, at a very minimum we would advocate that the person who should be making the order should be an independent person, not a senior officer from the organisation that employs the worker. It could be a member of the NSW Civil and Administrative Tribunal

[NCAT], for example, or ideally it could be a Local Court magistrate or, of course, if children are being included, a Children's Court magistrate.

The justification for the lack of appeal mechanisms—there is a limited review mechanism—the stated justification for the lack of appeal mechanisms is timing, but already the time frames within which the application process and the testing process are, of course, much longer than the time in which you have to act to start taking PEP and receive treatment if you think you're infected. So the stated justification for no appeal, being "time is of the essence," with respect, doesn't really wash with me. I would also just again adopt the position of others that children should be carved out completely from the operation of this bill. Thank you.

The Hon. TREVOR KHAN: Children or young people, or children and young people?

Ms SANDERS: Yes, if we are adopting the definition in the Care and Protection Act, then children are under 16, young people are 16 to 18. The definition in the Children (Criminal Proceedings) Act is under 18. So when I say children, to make it clear, yes, anyone under 18.

The Hon. SHAYNE MALLARD: I am interested into delving into that in a bit more detail. Why are you all advocating that children—under your definition of that Act, 14- to 18-year-olds—be carved out the bill?

Ms SANDERS: I should say that as well as being a member of the Law Society Criminal Law Committee, I run a legal service for children and young people. I am an accredited children's law specialist so I have given a lot of thought, obviously, to the impact of things like this on children. Children are uniquely vulnerable. I think in all sorts of legislative contexts, we draw a line in the sand at 18. Now we all know that 18 is an arbitrary line. There is no bright line between you being a vulnerable child and a mature adult the day you turn 18. However, we have chosen to draw that line and we recognise in a number of different contexts that children are uniquely vulnerable. I suppose on the one hand children do have their bodily integrity interfered with without their consent in many contexts if they are deemed to be not competent enough to consent to medical treatment in their own right. Children can be forced to undergo invasive medical treatment without their consent, but with the consent of a parent or somebody else.

So on the one hand this is already happening to kids. They can undergo certain procedures without their consent, but I do not think that is justification for something which has little or no therapeutic benefit to the child. If a responsible adult is sufficiently concerned that a child may be infected with HIV or hepatitis C or whatever, and the child is reluctant to undergo testing, if it is thought that testing would be of therapeutic benefit to the child there are applications that can be made in courts and tribunals for orders relating to the medical treatment of children. But the short answer is that children are uniquely vulnerable and our community recognises that in many different contexts. I might also say—and again the health experts know this better than me—the rate of HIV infections in particular among children and young people is very, very low. So the risks posed by children are likely to be much lower.

Ms BASHIR: I was just going to make that point. On the basis of the medical evidence in the submissions before you, the risk from children, and again we define that as under 18, is negligible. Again, it is not a reasonably proportionate measure to include children, that is people under the age of 18 years, so we would carve them out. And that is in addition to their vulnerability. We know that they are just not at the same levels of maturity often, and 18 is an arbitrary cut-off line. So in terms of their understanding of the procedure, and being subject to a forcible procedure, it can have a very different impact on young people than it can have on adults.

The Hon. TREVOR KHAN: Ms Bashir, you might have already said, but what is the position in Victoria with regard to children?

Ms BASHIR: I may have to take that on notice, but there is a large difference in Victoria. There, the Chief Health Officer or a senior medical officer, as defined in the Act, are the people who apply for the order.

The Hon. TREVOR KHAN: Indeed. Let me assume, and you can tell me if I am wrong, that at least your fallback position is that if this bill is to go forward then it should go forward, in a sense, modelled on the Victorian legislation. Would that be a fair analysis?

Ms BASHIR: If it is to go forward, there are safeguards that would ensure some criteria that attach some kind of necessity or medical opinion comes into play. At the moment, the way that the Act is structured, there is really no necessity to take the medical opinion into account. If there is a written report, it must be. But looking at the Act as currently drafted, I cannot see the criteria for consideration other than section 10 (5).

There is to be consideration:

> … of the guidelines issued by the Chief Health Officer under section 32 …

That is not even a "must take into account"; it is consideration of whatever they might say. We do not know. And:

> … other matters the senior officer considers relevant …

The Hon. TREVOR KHAN: It seems to me that it is section 9 (2). Well, it might be 9 (2). There must be discussion of the consultation.

Ms BASHIR: That is right.

The Hon. TREVOR KHAN: But it does not seem that then needs to be—

Ms BASHIR: Taken into account.

The Hon. TREVOR KHAN: Yes.

Ms BASHIR: That is where, in the Victorian legislation, there cannot be an order made—I have already indicated what it is subject to—unless under section 134 (1) (d):

> … the making of the order is necessary in the interest of rapid diagnosis and clinical management and, where appropriate, treatment for any of those involved.

That at least imports consideration of the medical situation as a criteria. We say that something like that—we have said certification. If there was certification it would be in writing, which would mean it would go into the application, which would mean it should be before anyone who is making the order.

If it is going to remain as a senior officer, at least they would have the medical opinion. The primary position of others, and an optimal position, would be that someone with some expertise would be making the order or the application for the order to the court. That is not the situation in the legislation as currently drafted. I cannot see in the legislation that it is mandatory to have regard to the medical opinion. I am sorry; the Public Interest Advocacy Centre has not had a chance to say anything. I hope that answers the question.

The Hon. TREVOR KHAN: It is always the problem with being on Webex.

The CHAIR: In that instance, I might give Mr Lawrie an opportunity to make a contribution on any of those points that we have raised so far.

Mr LAWRIE: Sure. I was just going to express our support for the views of our fellow panellists on children aged 14 to 17. In addition to the general reasons why we think mandatory disease testing orders should not be imposed, we would highlight the very low levels of bloodborne viruses in this cohort, but also the very high proportion of interactions of young people with police and/or corrections being Aboriginal and Torres Strait Islander young people. Therefore, we see a real risk that the vast majority of mandatory testing orders on children aged 14 to 17 would be on First Nations children.

The CHAIR: On a separate topic—something that we discussed in the previous session with a lot of the medical experts, particularly the AMA. I asked about the rights of the victim in this instance; the person who had received bodily fluid from—we used the word "attacker", which there was some objection to. For clarity, what are the rights of the person who has received that bodily fluid to have the reassurance that the attacker did not have a bloodborne disease at the time they transferred the bodily fluid to them? Even if medical evidence says that it is unlikely to provide transference, we heard this morning that there is a psychological attachment that hangs over that person for quite a period of time, and that the knowledge that they may not have had that transfer because they did not have a bloodborne disease would provide some reassurance. Does the victim not have that right to know that?

Ms BASHIR: First of all, I would say that this really depends on medical expertise in terms of what can or cannot be known. My understanding of the medical evidence is that you never have that proper reassurance of the negative test result because of the windows that are there. So, it is really difficult to answer that question. Our response would be that we defer to the doctors in terms of whether there can actually be reassurance. Others may have something else to say.

Ms SANDERS: I would adopt that. I would say the only true reassurance of course lies in the worker themselves—the victim—being tested and that test ultimately coming back negative.

The Hon. SHAYNE MALLARD: There is still that window there, too.

Ms SANDERS: Yes. As we have said, the aims are laudable. We are not suggesting that people who have been unwillingly exposed to bodily fluids, particularly if it is in an assault type of incident—we are not saying that their rights are unimportant. But this is not going to achieve anything.

The CHAIR: But that is the question that we have got to ask ourselves. You have spoken of the bodily autonomy of the perpetrator but I am looking at it from the perspective of the victim. Even if it provides a small amount of reassurance, they are the victim and this may provide the reassurance. I am curious because the AMA,

from a medical standpoint, adopted a medical position. As people who are representing views of the law, I am curious as to why you are advocating one way for, effectively, the autonomy of the attacker. The victim—even if it provides a small amount of reassurance—seems to have been lost in this whole conversation.

Ms SANDERS: Coming back to the medical evidence, it is really based on a false sense of security. Again, let me take it back to an example that I have already given. This is a highly politicised area. Let us look at bail, for example—somebody who has been assaulted or their house has been broken into. An alleged offender has been charged. They may be the real offender; they may not be. They may be guilty; they may not be. It may very well provide the victim with reassurance to know that the police have charged somebody and that person is behind bars and that person is not getting bail. Now, that person may well be the actual offender who is guilty of the offence. It may well be that the person who is being held behind bars with bail refused is completely innocent.

My point is that, in many cases, what a victim seeks by way of reassurance—sometimes a victim will seek by way of reassurance that the alleged offender is locked up behind bars, never to be released at all. In some very severe cases—mainly homicide—that may well be appropriate. But in many, many cases, what a victim may want or feel they need by way of reassurance is illusory. It is not actually going to ensure their safety, because the true offender might be still out there, or because locking somebody up for a short period is not going to address the real causes of the offending and it is only going to make the person more at risk of offending when they are released. Not only can the reassurance that a victim seeks be illusory, but it also comes at a real cost to the person who is alleged to have committed the offence or done the deed.

Remembering here—yes, we are talking about are victims, and you have used the word "attacker" or "offender". Yes, the bill does say "deliberate act". But coming back to the concerns that others have expressed, which I endorse, about what is a deliberate act—it is in the opinion of the person who has been exposed to this. It is: In their opinion, was it a deliberate act? There seems to be no objective criteria for what is a deliberate act. It does not have to be an unlawful act. So somebody might commit a deliberate act which is entirely lawful because it is in the pursuit of lawful self-defence, for example. Somebody might commit an act which appears to be deliberate but they are mentally ill. Of course, in healthcare settings that is likely to be happening reasonably often. They are so unwell that they are incapable of forming an intention to do anything.

The Hon. TREVOR KHAN: It is pretty clear from this that a mentally ill person—well, I suppose I imply it. Because a mentally ill person is defined as being a vulnerable person in the bill, it would seem that a deliberate though not criminal act by a very mentally unwell person would still be caught by this bill.

Ms SANDERS: That is right. The point is that, even though the wording "deliberate act" is used, the people who are committing these so-called deliberate acts are not necessarily offenders. They are not necessarily people who have a criminal mind and who would be judged guilty of a criminal offence in a court. We are looking at potentially innocent people or people who are not blameworthy being forced to undergo testing.

The Hon. SCOTT FARLOW: On that point, does that change the risk of infection though—whether somebody is doing it in an unlawful or a deliberate way?

Ms SANDERS: No.

The Hon. SCOTT FARLOW: In the sense of people who may have mental health issues or may be severely mentally impaired, it still comes down to the risk, which I guess is part of the choice of "deliberate" rather than "intentional" because that risk still exists there.

Ms SANDERS: Of course. But the reason why—and I think the Police Association of NSW allude to this in its submission—the drafters have chosen "deliberate act" is because it is fairly common ground that to force somebody to undergo mandatory testing, if they have accidentally exposed somebody else to bodily fluids, is beyond the pale. It is something that the community would find unpalatable. What we are doing is we are singling out people and saying, "Okay, well, they have done it deliberately. They are offenders. Therefore, their rights are less important."

The CHAIR: I want to give Ms Bashir and Mr Lawrie an opportunity to answer that as well. We were given two examples this morning on that theme. One was a guard or a police officer who might have been spat on by an individual who has gone on to claim that they have got every disease under the sun in order to create a level of fear and anxiety in that person when they do not have it. That is almost the reverse of what we are looking at. The mandatory testing might alleviate that psychological attack, which is more than the physical attack. On the flipside we also heard that if you are involved—say you are parked out on Macquarie Street at the set of lights and somebody hits the back of your car. You may be subject to mandatory testing for drug and alcohol even though you have not caused the accident.

The Hon. TREVOR KHAN: Yes, but it was more than that, Chair, for a start. It had to be a fatality. Put the whole scenario.

The CHAIR: Yes, I know. I understand that, but I am saying that you can just be sitting at a set of lights and be drawn into that. How does somebody who is in that scenario have less opportunity to object to mandatory testing than somebody who has attacked somebody else using bodily fluid?

The Hon. TREVOR KHAN: But it is not "attack", Wes. The example of a needlestick injury was used, because somebody has hidden a needle. That is not an attack, and yet that is a deliberate act.

The CHAIR: But it is a deliberate act.

The Hon. TREVOR KHAN: You are using the term "attacker".

The CHAIR: As I have phrased earlier, it is potentially—okay, a "deliberate act". Let me rephrase. Could you—

Ms BASHIR: Perhaps Mr Lawrie followed that better than I did.

The CHAIR: Apologies.

Mr LAWRIE: I am going to address a couple of issues that have come up since I last had the opportunity to respond. Firstly, in terms of the stress which a worker may feel or experience as a result of a possible exposure, absolutely, we acknowledge that that stress is a very uncomfortable situation to be in. However, we defer to the medical expertise of organisations that have appeared throughout the day. It seems to be close to unanimous that the best way to alleviate that stress is to adopt the best practice health responses to the situation. None of that depends upon compulsorily or mandatorily testing the person alleged to have exposed the person.

Secondly, on the question of deliberateness, this is not a frame that we would necessarily have chosen for the bill, but this is the frame that proponents of the bill have chosen. The proponents would say that this bill is necessary because our workers are being deliberately exposed to bodily fluids that are causing a risk of harm. In that circumstance, you would expect that there is at least a level of evidence provided about deliberateness beyond just the opinion of the relevant worker. You would expect that a decision-maker would come to a view about deliberateness rather than simply a general decision-making framework that it is justified in the circumstances. On that basis we think that, even using the framework that proponents of the bill have used, the bill fails.

The Hon. ANTHONY D'ADAM: On the question of the decision-maker, what is the evidentiary test? I think the PIAC submission dealt with this question about inconsistencies in terms of the test that is applied and whether it is beyond reasonable doubt or balance of probabilities. But for the officer making the decision, what is the sort of threshold that they have to be satisfied to in order to make the order?

The Hon. TREVOR KHAN: On the balance of probabilities seems necessary in all the circumstances.

The Hon. ANTHONY D'ADAM: But that is for the Local Court, is it not?

The Hon. TREVOR KHAN: Oh, yes.

The Hon. ANTHONY D'ADAM: Whereas I do not think there is a threshold for the decision-maker. In the Local Court it is quite clear. It is balance of probabilities, but what would be the standard that would apply in terms of the decision-maker for a person who is not a vulnerable person?

Ms BASHIR: The threshold does appear—I should not have used that word, but the threshold is very low. The word "appear" is used, so a senior officer is to determine an application for a mandatory testing order "if it does not appear to the senior officer, on the information available, that the third party is a vulnerable third party" in making the order. Then, as I said, the only criteria—which is a legal word that we use in terms of what must inform that—appears to be in subsection 5, which is consideration of certain things. Ordinarily an order that is a sort of civil-based order would be balance of probabilities, but where the word appearance is used—taking things into consideration—it is a very low threshold. It is another matter of concern in terms of striking the right balance.

The Hon. ANTHONY D'ADAM: How do they arrive at—well, do they actually have to be satisfied that it was a deliberate act? Or is that just purely based on the information provided by the worker?

Ms BASHIR: The application must be made in writing and contain the information set out in section 9, but it is very broad in terms of 5 (a) and (b), and (b) is really matters that the senior officer considers relevant.

The Hon. ANTHONY D'ADAM: Is it feasible that the Chief Health Officer guidelines might be able to set a test, or would that be beyond the kind of—

Ms BASHIR: Well, it still only has to "consider" it. It does not say "must take into account", for example. You could consider and cast something aside, making it mandatory for it to be taken into account—but it still only rises to the nature of a guideline. So criteria really should be in the legislation. Ordinarily we see that and we challenge legislation or decisions often on the basis that it is entirely unclear what criteria was applied to the decision-making. I would have thought for this legislation that it would be very important to have to take into account some kind of medical opinion even if it is simply at the level of risk—that there is a risk. We just do not see that in this legislation. That is why our safeguards would mean that there are some criteria which draw in the medics about it. So if one goes back to the first safeguard, which is that if alternative measures are available that are equally effective in ensuring rapid diagnosis and clinical management, then the least restrictive of the rights should be taken. But also there is that further provision that they have in Victoria, which we have said you could adopt.

If the medical practitioner is required to certify in writing that the testing of the person whose bodily fluid has come into contact with the prescribed workers is necessary in order to provide medical treatment, or the other phrases that are used in the Victorian legislation, what that would mean is, through the application of the Act, as it currently is, because it is in writing, that would need to be put before the senior officer considering it. But you would want there to be criteria picking it up as well, as something that must mandatorily be taken into account when the decision is being made. That is something that a court would look for.

The Hon. TREVOR KHAN: And medical treatment would include psychological wellbeing.

Ms BASHIR: Certainly.

The Hon. SHAYNE MALLARD: Well, it should, should it not?

Ms BASHIR: Certainly. And the Victorian provision includes "necessary in the interest of rapid diagnosis"—so it has that timing. If it is just not going to work in terms of the timing then there is no point to it—"and clinical management and, where appropriate, treatment for any of those involved". So it looks to actually treating the health issue and that must include, of course, the fears and anxieties and any mental health situation that any of the parties are experiencing.

The Hon. TREVOR KHAN: So do I take it that the Victorian legislation is also silent—sorry, not also silent but we will work on the basis that the New South Wales legislation is entirely silent—but it is silent on the question of the decision-maker having to determine the deliberateness of the act?

Ms BASHIR: It is just that - yes - the incident has occurred but there are criteria and it is the belief of the Chief Health Officer that an incident has occurred while a caregiver or custodian is acting in their capacity as a caregiver or custodian in which any of those involved in the incident were infected with a specified infectious disease and the disease could have been transmitted to any of the other persons involved, and any of those persons to whom the disease could have been transmitted has been counselled by a person. Anyway, I could read it all out but it is there. Would you like me to go on?

The Hon. TREVOR KHAN: Yes, I would, actually.

Ms BASHIR: Okay—has been counselled by a person of a prescribed class about the risk of transmission of the disease in the particular circumstances and about the medical and social consequences of being infected with the disease and, (2) has consented to being tested for that disease and (c) any of those persons who, if he or she were infected, could have transmitted it has been offered counselling, irrespective of whether the offer was accepted, and has refused to be tested for the disease, or is unconscious or otherwise does not have the capacity to consent to be tested for the disease, and the making of the order is necessary in the interest of rapid diagnosis and clinical management and, where appropriate, treatment for any of those involved. And it is all subject to subsection 11, which is that if there are other measures available, then you go to the other measures.

The CHAIR: Thank you. Mr Mallard has a question I believe, Mr Farlow, Mr D'Adam and then Mr Roberts and then we will probably be at time.

The Hon. SHAYNE MALLARD: Ms Bashir, I think you raised the issue of including Aboriginal and Torres Strait Islander people into the vulnerable category. I am interested in that. One of our great challenges and stains on our society is the disproportion representation of our Aboriginal and Torres Strait Islander people in our justice system. A fundamental platform of *Closing the Gap* is to reduce that. I am concerned that this, not through deliberate intention—I am not suggesting that about the police or prison officers—just by pure statistical fact the percentage is high and they are going to interact with a higher percentage. They are going to be put into another form of the justice system and again be represented disproportionately. It is problematic. Is that where you are coming from by saying that they should be moved into the vulnerable persons category?

Ms BASHIR: Quite.

The Hon. SHAYNE MALLARD: All right.

Ms BASHIR: The numbers have gone on up recently, even during COVID.

The Hon. SHAYNE MALLARD: Children are down but adults are up.

Ms BASHIR: Yes. Our particular concern is also for women in custody. I say that only because their overrepresentation numbers are higher as a percentage and so, what that would mean if they moved into the vulnerable category, it would not mean that orders could not be made but there would be the safeguard of it having to go to the court for an order. We see that as an appropriate safeguard if the legislation is to proceed in its current form.

The Hon. SHAYNE MALLARD: I mentioned *Closing the Gap*, which the States have signed up to in the latest version thereof, and one of the things that is fundamentally empowering Aboriginal people to make decisions—I mean, this is all white people here pretty much—so would you be able to suggest to us peak Aboriginal bodies in the legal area who could make submissions or we could talk to about their views this?

Ms BASHIR: Well, the Aboriginal Legal Service is in New South Wales the peak body. We do have a First Nation committee and a working party on overrepresentation of Indigenous people. I am a member of the overrepresentation working party. We consult with our First Nation committee also in terms of the submissions that we make.

The Hon. SHAYNE MALLARD: Okay. Thank you for that.

The CHAIR: Mr Farlow, do you have some questions?

The Hon. SCOTT FARLOW: Thank you very much. Ms Bashir, just picking up on the point made by the Chair earlier with respect to the anxiety faced by first responders when these issues occur, I am looking at the suggestions made by the Bar Association. What would you see, if the Government were to pick those up as part of the legislation, the timing impact would be in terms of those determinations, if those recommendations are picked up? At the moment it is sort of 72 hours that that authorised officer has to make that determination. Have you got any ideas you could give to the Committee?

Ms BASHIR: Well, just in terms of interaction with the court—or, you know, a review, for example—applications can be made to courts as a matter of urgency and it happens every day. The Local Court have people in custody for whom a bail application is made that morning and it is put before them as a matter of urgency. The Supreme Court has injunctions that go before duty judges. So, to suggest that matters, for example, going before a court cannot happen quickly is not correct. Here what we think is critical is the medical opinion. That is where there may be delays. That is why in the Victorian legislation it is the Chief Health Officer who has to approve the order. It means that there is a qualified medical opinion there. That is really where the delay might come in. But in terms of the legislation itself, these things can happen very quickly. I did raise that in terms of the review mechanism.

In the first draft, as I understand it, there were two days. Now it is one day in terms of a review for there to be an application for review and the sample is taken anyway. That really should be repealed. It should not be in there and there should be a period of time, even if it is just a quick time—and when I say what should be repealed, there should be a stay on the execution of the order pending the review, even if the review has to be done very quickly. Does that address your questions about timing?

The Hon. SCOTT FARLOW: Yes. Thank you.

The CHAIR: Mr D'Adam?

The Hon. ANTHONY D'ADAM: Mine is a bit more of an abstract question. The central controversy of this bill is about when the state should infringe on the bodily autonomy of a person. We have heard in some submissions that this is a foundational principle in medical ethics but what is the root principle at law that underpins the assumption that this is an inappropriate step for the State to take?

Ms BASHIR: Mr Lawrie probably needs a turn to answer that.

The Hon. TREVOR KHAN: Because it is a physical assault on the individual.

Mr LAWRIE: I am happy to take that on notice to give that proper consideration.

Ms SANDERS: I can answer briefly but it is, as Mr Khan has just said, a physical assault. Of course different cultures, different countries, different regimes perhaps have different values or different priorities but certainly our society and our legal system value personal liberty and bodily integrity very highly. Any kind of forced medical treatment without the person's consent is an assault, unless of course it is justified by being

emergency treatment to save someone's life in circumstances where they cannot consent because they are unconscious, for example. And just remember the mandatory testing of a person, the person who has done the allegedly deliberate act, is of no therapeutic value.

So generally, medical testing or medical procedures can only be done without someone's consent if they are necessary for the person's wellbeing—if they have some therapeutic value. Of course, there are situations when—and Mr Fang has given an example of if somebody is hospitalised as a result of a motor vehicle accident, there are provisions for mandatory blood testing there. So yes, Parliament has seen fit to—and there is also forensic procedures legislation. So yes, there are situations in which authority is given to do invasive things—whether that be taking people's blood samples, hair samples or whatever—without their consent in certain circumstances. But it is a principle that our legal system and I think our community, our society and particularly the ethics of our health professions value very highly.

Ms BASHIR: And it is a matter of liberties. It is a matter of rights and freedoms and the freedom to be—

The CHAIR: Sorry, we are out of time, but I know that Mr Roberts indicated that he had a question. He has not asked one yet. And Mr Khan does as well. I wanted to give both of them the opportunity..

The Hon. ROD ROBERTS: Ms Sanders, did you have the opportunity to listen to the evidence earlier today or were you preoccupied?

Ms SANDERS: Unfortunately I did not, no. I have read the submissions, but if the evidence went beyond the scope of that, I cannot—

The Hon. ROD ROBERTS: I am going to ask a question that I asked earlier today of another witness. You rightly suggest and state that we should listen to the health experts in relation to this, particularly the NSW Health department, as they have led us through COVID quite successfully et cetera. I am going to draw your attention to a policy directive document from the NSW Health department that is related to HIV, hep B, hep C and the management of healthcare workers who are potentially exposed. Their document says to their own healthcare workers inside the department of health that:

> If the blood borne virus status of the source patient at the time of the incident is unknown, the staff conducting the risk assessment should arrange for the source patient to be tested as soon as practicable for HIV, HBV and HCV infection … Results of source testing will better inform the exposed HCW about the risk of transmission and where PEP has been initiated, inform the need for continuation.

Can you comment on that?

Ms SANDERS: I can comment on that because I have read the submissions that address that. Obviously, that contemplates that the source patient will consent to the testing. There is certainly nothing in that directive—

The Hon. ROD ROBERTS: But it is best practice, though.

Ms SANDERS: It is best practice. Of course it is best practice. I think all of us would agree that it is desirable that a source patient would be consenting to testing. However, the testing of the source patient does not in general—and again I would ask you to defer to the medical experts; I think the Australian Medical Association [AMA] explains this quite well, as do some other submissions—assist in making a decision about whether to administer PEP, or post-exposure prophylaxis, which has to be administered within 72 hours. The testing of the source patient is irrelevant to that decision. Where it is relevant is in the more long-term treatment. So in the case of HIV, whether the source patient is positive or negative to HIV will perhaps inform the decision as to how long the PEP is administered for in the person who may have had HIV transmitted to them.

In terms of hepatitis B, I understand that the decision as to whether or not to administer PEP depends largely on whether the recipient has actually been vaccinated against hep B. So yes, I agree that the testing of the source patient is desirable, but it is more likely to inform the more long-term aspect of the treatment and not the immediate short-term aspect. If you are testing a source patient within the relatively short time frame that this bill contemplates, there are going to be problems with window periods. You are never going to be quite sure whether the test is a true reflection of their status on the day. So that is the best I can do to respond to that. Again, I would commend to you submissions of the AMA and other bodies.

The Hon. TREVOR KHAN: We received some evidence this morning, particularly from the Police Association, where questions were asked with regard to essentially the circumstances in which a senior officer can require a blood sample to be taken, as in this one. One of the examples that they gave, apart from the fatality exercise, was the forensic procedure. I have not had a chance to check, but there is a difference between what I think is called an intimate procedure and what I now cannot remember—it has been so long since I practised.

Ms BASHIR: That is right.

Ms SANDERS: Correct. A non-intimate forensic procedure, which may involve a photograph or something like that—

The Hon. TREVOR KHAN: A hair sample?

Ms SANDERS: A hair sample or a buccal swab to take a DNA sample—those are basically classified as non-intimate. With children, of course, any forensic procedure requires a court order, or incapable persons—so people with cognitive impairments who do not have sufficient understanding.

The Hon. TREVOR KHAN: So those ones can be—

Ms SANDERS: Those ones can be court ordered. A non-intimate is with the informed consent of the suspect or an order of a senior police officer. An intimate forensic procedure, which includes a blood sample: informed consent or court order.

The Hon. TREVOR KHAN: But also other things: genitalia and the like.

Ms SANDERS: Things like that, yes. There is a whole long list of them. But a blood sample, unless it is with the informed consent of the suspect, has to be a court order.

The Hon. TREVOR KHAN: So we should not take from any evidence that we have received today that a senior officer under a forensic procedure can direct a blood sample to be taken?

Ms SANDERS: No, they cannot.

Ms BASHIR: No, no. Could I just very quickly say that that is because of our right to bodily integrity and to not have samples removed from our body. That underscores the Bar's request that there be amendments requiring the destruction of those samples even if the legislation is enacted. You just do not see that, but it is court ordered.

The Hon. TREVOR KHAN: One of the things that has interested me in this legislation is it seems to be wide enough to cover the throwing of urine or the spitting of saliva.

Ms BASHIR: Substance.

The Hon. TREVOR KHAN: And I have to say, as I said, I had an unhappy client who gave me a face-load once. But it seems to me we are saying that if somebody is spat on, it must necessarily lead to a blood test. It seems to me interesting that if the means of transmission is said to be, for instance, spit, that it necessarily leads to a blood test.

Ms SANDERS: Even the Police Association is walking back from spitting. They say in their submission, "Oh, if we were suggesting that spitting—even though it is disgusting—may pose a real risk of transmission of bloodborne diseases, then we resile from that. Sorry, we do not mean that." So even they are saying spitting is not really an issue. The risk of transmission of anything through spitting is very, very low. Some forms of hepatitis—I think it is hepatitis B maybe—are transmitted by spitting, but even then it is through saliva and even then the risk is very low.

The Hon. SHAYNE MALLARD: Do you have medical evidence on that?

Ms SANDERS: Yes.

The Hon. ROD ROBERTS: Just as a point of clarity: we talk about spitting and the natural inference from that is saliva. What about if we are talking about the spitting of blood, though? So it is actually blood through the action of spitting but not through saliva. There needs to be clarity in relation to that. So if they do say they spat, maybe perhaps we are hearing—well, if you spat saliva and saliva only, maybe there are questions there. However, if you spit blood, it is still the action of spitting but now we are transferring blood, not saliva.

The Hon. SHAYNE MALLARD: It is blood.

Ms SANDERS: Yes.

Ms BASHIR: Bodily fluid does include saliva in the definition as currently drafted.

The Hon. ROD ROBERTS: Sure, but we are talking about the act of spitting itself.

The Hon. SHAYNE MALLARD: We had evidence today from the medical experts who said that blood is the only way these viruses can be transferred—not spitting, not urine, not faeces.

The CHAIR: I will take this opportunity to say thank you very much for appearing today, and thank you for indulging us with some extra time. We have resolved that any questions on notice will be returned to us within 14 days. The secretariat will be in contact with you in relation to the questions that you have taken on notice.

(The witnesses withdrew.)

(Short adjournment)

NATALIE LANG, Branch Secretary, Australian Services Union NSW and ACT (Services) Branch, sworn and examined

The CHAIR: Would you like to make an opening statement?

Ms LANG: I would, thank you very much, Chair. I would like to thank the Committee for the opportunity to appear before you today. Every worker should be safe at work. They should have safe workplaces, safe systems of work and the resources and equipment necessary to carry out their work in a way that protects their physical and psychological wellbeing. Occupational violence is an unacceptable health and safety risk. The trauma and vicarious trauma associated with occupational violence is equally unacceptable and can be long-lasting.

The proposed mandatory disease testing that the Committee is considering does not make workers safer. It will not reduce occupational violence and associated trauma. Rather it will likely increase the occasions of occupational violence, physical and psychological injury, and vicarious trauma for the very workers it is designed to protect. It will create new and additional health and safety risks to other groups of workers such as the frontline community and disability workers who support marginalised, vulnerable, socially excluded and at risk community members. Mandatory disease testing is ineffective and counterproductive. It does not address the real occupational health and safety issues confronting frontline workers. It is therefore simply an unjustifiable attack on the human rights and civil liberties of people who may have specific vulnerabilities and those who are most likely to be stigmatised.

The Australian Services Union [ASU] represents workers throughout the not-for-profit and social and community services sector, including many frontline workers. We represent workers employed by organisations providing services to the LGBTIQ communities; people who are homeless, in the youth justice system or penal system; First Nations peoples; young people; and people living with intellectual, cognitive, and physical disabilities, including mental health issues. The union is a very active and outspoken advocate for stronger workplace health and safety standards, including a much stronger compliance regime.

We agree with Minister Elliot when he said in his second reading speech that frontline workers are often confronted by an unacceptable level of risk arising from their occupation. As the ultimate employer of those frontline workers, the Government does indeed have a legislated responsibility to do everything possible to provide a safe workplace and to prevent workplace injury to those workers. Frontline workers, indeed all workers, should always have ready access to personal protective equipment, infection control and other safety training, based upon strong scientific evidence. We condemn any assault against any worker, regardless of health risk.

However, Australian and international evidence, some of which has been presented to this Committee, demonstrates unequivocally that mandatory disease testing is entirely ineffective in preventing or reducing harm or risk to frontline workers involved in potential exposure incidents. The proposed legislation is simply not supported by scientific evidence. It does not take into account existing successful frameworks for managing occupational exposure to bloodborne viruses, including HIV and hepatitis. It does not consider the counterproductive and negative consequences of mandatory disease testing. It does not address the many very real and urgent occupational health and safety issues confronting frontline workers that have been identified by evidence-based research. The proposed legislation is very bad public policy. It is not fit for purpose and it should not be passed into legislation.

The CHAIR: Thank you, Ms Lang.

The Hon. ANTHONY D'ADAM: Thank you for your appearance today and thank you for your submission, Ms Lang. Obviously you do not believe that the mandatory testing regime is the way to go, and we have heard evidence today about the psychological harm from being in a situation where you are exposed to a bloodborne disease. What are the alternatives to deal with the psychological risks that arise out of that situation? I am sure that you have members in the various industries that you cover where they are routinely exposed to those types of situations and risks. There are obviously other alternatives. What are they?

Ms LANG: Thank you very much for that question. Firstly, we do not believe that mandatory testing will reduce the instances of occupational violence; that is a very significant concern for us. Indeed, we actually believe that mandatory testing regime will increase incidences of occupational violence. Most noticeably, that is because many of the communities that are most at risk of being engaged in those instances of occupational violence already have a level of distrust with authorities and with frontline workers. The legislation is only going to exacerbate that trust relationship, or the lack thereof. In particular, though, for our members who work in frontline community services, they are often on the front line of being asked to attend with first responders to assist marginalised communities that are at risk of being involved in such incidences. The reason they are asked

to attend is because they have a very strong practice of developing trusting relationships with marginalised communities. This is actually going to put our members at very significant risk of themselves being exposed to occupational violence—when we talk about the threat of mandating blood testing regimes.

In terms of what can be done with regard to the psychological injury, I think that is a really important point for us to consider because it is a very significant work health and safety issue that we need to address. The problem is that a mandatory disease testing regime will not alleviate psychological injury. We know that there is a very significant risk that somebody who is subjected to mandatory testing can return a negative result because of the testing period window. So the worker who has been exposed to an occupational violence incident or a transmission of bodily fluids, as opposed to transmission of bloodborne disease, will still have that degree of uncertainty and trauma that is associated with the occupational violence incident that led to bodily fluids to be exchanged.

What we need is vicarious trauma support for our frontline workers that is accessible to every single worker, regardless of whether somebody is aware of the risk that is associated with a bloodborne disease based on fact or fiction. The trauma is going to continue to exist when that transmission of bodily fluids is a result of an occupational violence incident. So vicarious trauma support is going to be a really important way that we can combat that adverse psychological impact of an occupational violence incident.

The CHAIR: In the instances that you just described you said that it is unlikely to alleviate the psychological trauma. That flies in the face of the evidence we heard this morning from the PSA and the Police Association of NSW who said that for their members, the legislation will provide a great deal of relief, particularly with the psychological aspect. They are not your members who are going to be predominantly affected by this and they are the unions that represent them. They are saying that this is something they want because of the psychological effects on their members. How do you put your members ahead of their members when it is their members who are being directly affected by this?

The Hon. TREVOR KHAN: Wait a minute, Chair. You need to look at the schedule to the bill. It is not just the PSA and the Community and Public Sector Union that is covered by the bill. To be fair, if you look at the schedule, there is a whole range of groups of workers. The witness and her union is entitled to have a different view. I do not think it is fair to say that one has priority over another.

The CHAIR: That is not what I said, Mr Khan.

The Hon. TREVOR KHAN: I think it is pretty close to it.

The CHAIR: I was listening to the answer that Ms Lang gave, which was that for her members, it provided a great deal of risk because they would be providing support to the frontline workers who may have to go and do the testing or deal with the people after they have had the testing enforced on them. Whereas, for the frontline workers who gave testimony this morning—

The Hon. TREVOR KHAN: If you look at the schedule, there are more frontline workers than simply those who appeared this morning. I am not belittling their evidence, but if you look at the schedule, it is a whole range of people who are covered by the bill.

The CHAIR: I accept that. What I am asking is: How does Ms Lang quantify that the effect to her members is lesser because of trying to support the other unions' workers?

Ms LANG: Firstly, we are not going to suggest for a moment that the right to safety for one group of workers is any greater than the right to safety of another group of workers. Right now there is not the same risk of occupational violence to our members without the testing regime than there would be with a mandatory testing regime. That would be a new risk which would be presented to our members. It is not just about once there has been an instance of bodily fluid exchange. For example, at the end of 2019 and beginning of 2020 we saw rough sleepers being moved on from Martin Place and Eddy Avenue. When police went and moved on rough sleepers it was our members, who are homelessness service workers and mental health workers, who were required to go along and assist in that time of moving on. That is a perfect example of the kind of time where we may see issues of occupational violence arise for the workers who are moving along marginalised, distraught and traumatised communities. We have members who are peer workers, who will attend things like dance parties or a Mardi Gras party to support members of communities who are engaging in those festivities to do so in a safe way.

Again, if we hypothesise that these are potentially instances where we may have a conflict arise between frontline workers of law enforcement and members of at-risk communities, it is our members who are going to be in the thick of that instance of occupational violence, trying to keep everybody safe. So, it poses a new risk to them when trust relationships between authorities, our members and the communities they are there to support are broken down. We have to remember that there are already a lot of communities that do not have a particularly

fantastic, trusting relationship with authorities. Our members are often asked to be involved in those circumstances, to keep everybody safe. This is only going to exacerbate that risk.

If I can go to the issue of the assertion that I made in my opening statement, I do not believe a mandatory testing regime will actually assist with the psychological trauma of the workers this bill is designed to protect if they are exposed to occupational violence situations. There are a number of reasons for that. Firstly, the reason for a lot of the desire to have a mandatory testing regime in place is not based on scientific evidence about how bloodborne viruses are transmitted. It is based on myth and it is based on stigma. This bill proposes to apply in instances where saliva is exchanged as a bodily fluid. There is no scientific evidence that suggests that saliva can transmit a bloodborne virus.

The concern here for frontline workers—who, through no fault of their own, are being exposed to psychological injury and angst over whether they have been exposed to bloodborne viruses—is only going to be exacerbated by a regime which continues to perpetuate falsehoods, misinformation and stigma associated with bloodborne viruses and illnesses. It is going to make the situation worse because we are legitimising an argument that bloodborne viruses can be communicable by way of saliva. That is simply not supported by facts. So, that is one of the fundamental problems with the regime that is being proposed. In New South Wales—this is a good thing—we have low rates of HIV and other bloodborne viruses in our community. That is not happening by accident. It is happening because of a fantastic public health and public health education response that is delivered by our members in health promotion organisations.

If we continue to perpetuate the stigma and the falsehoods of how bloodborne viruses are transmitted, or stigmatise particular communities who may be at particular risk of having bloodborne viruses, we are going to have an adverse impact on our public health response. We know that the secret—much like the secret around how we are keeping COVID-19 at bay, may I add—is to encourage testing. It is to remove the stigma from somebody who might be concerned that they have a bloodborne virus. They are not going to be labelled. They are not going to be shamed. They can come forward for testing. "Test early, test often"—I have heard our own Premier say that. "Test early, test often" is exactly the same response that we need when it comes to managing bloodborne viruses in our community.

If we perpetuate the falsehoods of how bloodborne viruses are transmitted and potentially stigmatise at-risk communities, it will adversely impact all the good that has been done by our public health system in health promotion, where we remove the stigma of HIV, hepatitis and bloodborne viruses and we ask people to come forward for testing, manage infection, seek treatment, and do so in a positive way. This is a very dangerous proposal that we have before us, not just for the workers who it is supposedly designed to protect and not just for our members, who potentially will be exposed to new forms of occupational virus, but for our community at large. If we once again stigmatise bloodborne viruses so that people do not engage in testing and treatment regimes, we are doing a disservice to every single member of our community, of every age.

The Hon. SHAYNE MALLARD: Well said.

The Hon. SCOTT FARLOW: Just picking up on that point, Ms Lang, a mandatory disease testing regime exists in every other State across Australia, to varying degrees. Is there any evidence of an impact that has had in terms of testing in other States?

Ms LANG: I do not have that information at hand, but I would comment on the premise of your question around the existence of testing regimes in other States. It is important to note that the proposal for the testing regime in New South Wales is not one that is centred in and guided by a public health regime. It is not about a piece of public health legislation with public health directives subject to being overseen by subject matter experts from a health perspective. In contrast to that, the Victorian model requires approval by a magistrate for a mandatory test to be undertaken and the magistrate is required to be satisfied of the actual risk of the circumstance of a bloodborne virus being communicated.

Simply being spat on—which is not an okay thing to occur—and being concerned that you may have contracted or been exposed to a bloodborne virus as a result is not a trigger to undertake a mandatory test in the Victorian regime. It is not a matter for a senior officer in any sector, other than the health sector, to approve such a test to be undertaken. It is actually based on scientific evidence. A magistrate must approve it and must get advice from subject matter experts around bloodborne viruses, who will assess the circumstances of that particular incident and whether there is an actual risk of a bloodborne virus being communicated. That is really important when we come to your original question, Chair, about the psychological injury that is caused to workers when they are uncertain, scared or concerned that they may have been exposed to bloodborne viruses.

As it is proposed, this bill will only perpetuate the fear that you may have been exposed to a bloodborne virus when you simply will not have been exposed to any risk of a bloodborne virus. The mandatory testing regime

that exists in Victoria is based on evidence. That is the best comfort we can give to frontline workers because that is where an expert in bloodborne viruses will be advising a magistrate, who will be the decision-maker about whether there is an actual risk of a bloodborne virus having been communicated to the frontline worker. I know that if I was a frontline worker and I was being assured on the examination of my circumstance, and a subject matter expert in bloodborne viruses was able to tell me there was no risk of me having contracted a bloodborne virus—that would be the best comfort I could get for the fear and uncertainty I would be facing, not undergoing what will be a very timely regime to undertake testing.

We know that the treatment will not change. If you have been exposed to a potential risk of contracting a bloodborne virus, you start post-exposure prophylaxis [PEP] straight away. That is the expert advice. You will be on the same testing regime and going through months of uncertainty because, as we know, even if the test returned a negative result it is not necessarily reliable because of those testing windows. The best comfort that a worker can be given is where a subject matter expert has examined their particular circumstance, whether it is spitting, biting, vomiting or whatever bodily fluid transmission, and assessed if there is a real risk of a bloodborne virus transmission having occurred. That is the difference between the Victorian testing regime—and why there have been so few tests carried out in that regime—and what is being proposed here.

I would encourage the Committee to consider that there is a reason this regime is being proposed. We are being told that it is to keep our frontline workers safe and to alleviate the fear, anxiety and concern that frontline workers experience when they have had bodily fluids put on them in an occupational violence incident. This bill will not do it. If we look at the Victorian regime, a magistrate must approve it. It rests in public health legislation. It is overseen by public health experts and it considers the actual circumstance of those bodily fluids having been exchanged. That is what will actually deliver comfort to workers, not what is being proposed here.

The CHAIR: Ms Lang, as I posed in my original question, while you say that, in your instance if it had occurred to you, you would find comfort from the knowledge that a communicable diseases expert had been involved in your case, et cetera, the other unions which presented to us today and their members have said that they want the reassurance that the person that has deliberately provided a bodily fluid to them does not carry those diseases. While you might find all that reassuring to you, it may not be reassuring to those members and it is their union that is asking for this to occur. Again, I ask why your union's view counteracts or overrides the unions and associations that we heard this morning when it is their members who will be directly affected by the reassurance provided.

Ms LANG: It does not provide reassurance. It simply does not. You can tell somebody it provides reassurance; they might believe you it provides reassurance but, quite frankly, it does not. It is based on falsehoods around how bloodborne viruses are actually transmitted. Quite frankly, I think it is negligent to tell a worker who has suffered an occupational injury that they can take comfort in the fact of a returned negative result that was taken against the will of the person because it will not actually assure that worker who has been exposed to the occupational violence incident that they have not been exposed to a bloodborne virus. As we said, the scientific evidence supports that there are testing windows in which a person who is HIV or bloodborne virus positive will be positive and will be transmissible but will not return a positive result because of where they are at in the stage of their infection. Therefore, if we are going to take the best public health response to keep that worker safe, you are still going to act like they have been exposed to the bloodborne virus so that they see through the entire treatment to make sure that they are actually safe.

The risk of perpetuating falsehoods around how bloodborne viruses are actually transmitted only increases the psychological harm to those workers. What would alleviate the concern of a worker is knowing the truth around how bloodborne viruses are transmitted. The truth is that they are not transmitted by way of saliva or when they fall on unbroken skin. I encourage the Committee to consider these shortcomings of this proposal and think about all of the evidence that you have been provided by other witnesses, not just myself, who are subject matter experts on bloodborne viruses around building a system that actually protects workers. Telling them that it is all okay because we papered over an actual work health and safety risk does not keep those workers safe. We are telling them that they are at more risk than they actually are. They will have to live with that uncertainty and trauma for months. We are creating more trauma to those workers by implementing a system that is not based on scientific fact.

The CHAIR: Say a cohort of your members—one of the groups that you represent, that is, allied workers and the like who provide services to the homeless that you spoke about earlier—came to your organisation and said that they have had a discussion around this and would like similar protections—that if frontline emergency service workers are going to have this testing available to people that communicate—spit or have blood put on them—they would like the same protection. Would you advocate for what they want and the reassurances provided to them? Or would you provide them with similar arguments as you have provided this Committee now?

Ms LANG: Thank you for the question about our democratic processes. We are a very proudly, devoutly democratic union. Our members come together and make decisions about the direction and position that we take on matters, just as our members who work in the community sector—indeed, many of them—have made submissions and appeared as witnesses to this inquiry have done so on the position I bring to you today. It is incumbent on all of us to ensure that, when people are asking or raising a concern with us or telling us a concern that they have and are asking for a solution, that we provide the real and accurate information that is going to assist them to make an informed decision. The subject matter experts on the matter of bloodborne viruses have made it very clear under what circumstances bloodborne viruses can be transmitted.

That is the information that we would be making available to our members in those circumstances so that they can make informed decisions. People will often ask for something that is not necessarily in their interests. We all know what to do in those circumstances. It is actually to talk about what the underlying issue is here and what is the information they need to be able to make an informed and accurate decision based on truth and evidence. My children can ask me every single morning for chocolate cake for breakfast because they think it will start their day better. That does not make it a good decision. I will talk to my children about what are the sometimes foods or what are the all-the-times foods. It is a hard process to go through, but it is an important process to go through because in the end it is about the health and safety of our community.

The Hon. ANTHONY D'ADAM: Assuming that the Parliament does not accept your submission that the bill be rejected, I invite you to place on record suggestions around possible amendments that might be put forward. We have heard a number of submissions today. I think the NSW Bar Association recommended that Indigenous people be placed in the vulnerable persons category so they have that additional level of oversight and protection. I invite you to outline some of the areas that might be appropriate amendments for Parliament to consider to perhaps mitigate against the more adverse elements of this bill.

Ms LANG: I would like to, with the indulgence of the Committee, request to give you a couple of the headline responses but also the opportunity to take that on notice and provide further information which can be more considered.

The Hon. TREVOR KHAN: In that regard, I invite—it is obviously going to take at least week for the transcript to go up. Perhaps have a look at the evidence of Ms Bashir from the Bar Association and see whether you agree or disagree with some of the propositions that she put forward with regard to tweaking the bill, if I could describe it that way.

The Hon. SHAYNE MALLARD: It is in detail in her submission too.

The Hon. TREVOR KHAN: Yes, there is some in the Bar Association submission as well, but she went a bit further than that.

Ms LANG: Thank you and I will take the opportunity to do that. Without going into the finite detail, we need to change the application of this to minors as young as 14 years old. I shudder at the thought that we would do this to children, especially considering there have only been three cases of HIV-positive young people in that category in New South Wales in the last year. It needs to be overseen by a magistrate to approve and not what is currently designated—a senior officer who, indeed, may have no expertise in the relevant matter of bloodborne viruses. Such a model would be receiving advice from subject matter experts in bloodborne viruses and considering the actual circumstance of the incidence in question when the magistrate would be making such a decision.

The appeals process is problematic. That somebody could still be required in the current proposal to have to give a sample whilst under appeal is a major problem that would need to be amended. There are concerns around the privacy, collection and storage of data about somebody's health records that I know would also need to be considered, as well as the scope upon which such a model would apply. Like we said, the scientific evidence does not support in any way, shape or form that bloodborne viruses can be transmitted by saliva. I think it is unacceptable to then include that in the scope of the legislation. I would be more than happy to take that on notice and provide more detail under those particular headlines that I have just jotted on the piece of paper before me while responding to your considered question.

The Hon. TREVOR KHAN: Could I just deal with the final issue, and that is the exclusion of saliva? I make plain that if it was that either the Chief Medical Officer or a delegate or a magistrate who relied upon medical advice was to be the decision-maker, why do you need to exclude saliva in those circumstances? If what you do is you place this in the hands of a proper decision-making mechanism, is that not then the answer? I raise the question, as Mr Roberts did earlier: Are you dealing with a saliva case or are you dealing with a very blood-rich mixture that is sprayed into the face of an officer or worker of some sort so excluding it may create a problem that really is unnecessary to do?

Ms LANG: Yeah. Look, thank you for the question. I believe that having it overseen by a magistrate and experts in blood-borne viruses goes some way to addressing it but I do not believe it goes all the way to addressing the concerns that we have around the inclusion of bodily fluids such as saliva and that is because of the earlier this year I spoke to around the impact that such a matter would have on the public health response and the health promotion response. So it would continue then to perpetuate the falsehoods around how local viruses are transmitted. Again, that then runs a very serious risk of undermining our public health response, which is encouraging people to not feel stigma, to not be stigmatised, to not be labelled and to be able to come forward and undergo testing. If we perpetuate falsehoods around how blood-borne viruses are transmitted, then it undermines that public health response.

Again, it goes to the earlier question that the Mr Fang raised which is around the psychological injury to workers. Again, if we perpetuate falsehoods around how blood-borne viruses are transmitted, workers who are exposed to those bodily fluids will live with that fear that they may have been exposed to a blood-borne virus when they simply have not been. So excluding it would go some way then to addressing what is that serious concern that workers have that if they have been spat on, for example, or bitten where saliva has been the bodily fluid and where they do not have a risk of having contracted a blood-borne virus in that circumstance, but if we continue to have that in the legislation, then it is likely that workers would continue to be concerned—that if that was the type of bodily fluid they were exposed to they were potentially exposed to a blood-borne virus when they simply have not been.

The Hon. TREVOR KHAN: Right. Could I ask you this: The most likely circumstance of transmission is likely to be in a health environment—that seems to be the evidence and it seems to be common sense—and probably the most likely is either needlestick or cutting with a scalpel or the like. Let us assume that is the most likely. Some of that may be covered by this legislation in the context of a ready patient in accident and emergency, say, but there are many other circumstances in which needlestick injuries or cuts occur through a glove or the like, and let us suppose that what we have is an automatic patient, say, a patient who is unconscious in some way but nevertheless is thrashing about. It certainly happens. That would not fall into the striking or whatever else that leads to the needlestick or the cutting and would not be covered by this bill at all. But actually in terms of the likelihood of infection, or the possibility of infection, is far greater. Do you see any circumstance where there should be provision for health workers—for instance, if the patient is unconscious—or that there should be a capacity for a test to be done of the patient in those circumstances to alleviate their perhaps far more legitimate concerns of infection?

Ms LANG: No.

The Hon. TREVOR KHAN: No?

Ms LANG: This matter is already dealt with currently in our health regulations, and our health regulations from the Ministry of Health are around how to respond in an occupational situation where somebody is exposed to a needlestick injury. To take that example, it is to treat the person as if they have been exposed to a blood-borne virus, commence the treatment immediately, see the treatment out. It will not change the health response that that worker receives. Again, I go to that concern around potentially returning a false negative, which can put the worker at greater risk when potentially they do not finish the course of treatment when they have actually been exposed to a confirmed case. That seems negligent to me. It seems like we tried to fix the problem that did not exist. The idea that we do not know how to treat a worker who is exposed to a needlestick injury is not a real problem. We know what to do if a worker is exposed to a needlestick injury. We treat them as if they have been exposed to a blood-borne virus. We commence treatment immediately. We commence counselling immediately for the potential psychological resultant psychological injury. Testing would not change what that response is. Indeed, it could actually undermine that response and put somebody at greater risk. I mean, don't solve a problem that does not exist would be my view.

The Hon. TREVOR KHAN: Right. Look, my final question is this: You say that children should not be subject to this regime. Does that mean somebody under the age of 18 or does it mean somebody under the age of 16?

Ms LANG: I would be happy to take the question on notice and seek advice.

The Hon. TREVOR KHAN: Whether it is justified or not, in my mind there is actually a difference between those two age categories I have to say.

Ms LANG: I agree, but that is my personal opinion. I mean, we see young people who are residing in youth homelessness settings even beyond the age of 18 because they are assessed for other means to still be in need of the services that are tailored to support a child, to support a young person.

The Hon. TREVOR KHAN: Yes.

Ms LANG: So I do not think it would be acceptable to than treat them like an adult who is making a sound decision to engage in a behaviour of a particular way when they simply are not.

The Hon. TREVOR KHAN: True. But, for instance, a 16 year old can engage in sexual intercourse quite legally. We actually do provide some degree—and I think in terms of medical treatment as well—of legal autonomy to 16 year olds that, for instance, we do not afford to a 14 year old. I think there are gradations along the way. Indeed, this was a matter of some conjecture in this Parliament with regards to 18 and 16 consent.

The Hon. SHAYNE MALLARD: The age of consent.

The Hon. TREVOR KHAN: Yes. I am not convinced by the argument that 18 is a hard-and-fast age. I have not heard a lot of subtle interaction on the different rights that apply in a gradated way in our society.

Ms LANG: If the Committee would indulge me, I would be very happy to take that on notice and form a stronger view.

The Hon. TREVOR KHAN: You are quite allowed—quite.

The CHAIR: I just want to check: Does any other member have any questions for the witness before we draw our hearing to a conclusion?

The Hon. SHAYNE MALLARD: No. I found the evidence compelling.

The CHAIR: Well, in that instance, thank you very much for your evidence this afternoon. It has been very enlightening, especially in the last session of the day. It is good to have someone so engaging and forthright. The Committee has resolved that answers to questions on notice be returned to us within 14 days. The secretariat will contact you in relation to the questions you have taken on notice. That draws to a conclusion today's hearing. Thank you very much.

Ms LANG: Thank you, Committee.

The Hon. SHAYNE MALLARD: Thank you, Ms Lang. That was very good.

(The witness withdrew.)

The Committee adjourned at 16:39