REPORT ON PROCEEDINGS BEFORE

STANDING COMMITTEE ON LAW AND JUSTICE

MANDATORY DISEASE TESTING BILL 2020

CORRECTED

At Jubilee Room, Parliament House, Sydney on Friday, 12 February 2021

The Committee met at 9:30 am

PRESENT

The Hon. Wes Fang (Chair)

The Hon. Catherine Cusack
The Hon. Anthony D'Adam
The Hon. Greg Donnelly (Deputy Chair)
The Hon. Trevor Khan
The Hon. Taylor Martin
The Hon. Rod Roberts
Mr David Shoebridge

The CHAIR: Welcome to the second hearing of the Standing Committee on Law and Justice Inquiry into the Mandatory Disease Testing Bill 2020. The inquiry is examining the provisions of this bill, which would 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 the 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 the NSW Police Force, which has put forward this bill, and other government agencies who will have a role in the operation of the proposed mandatory disease testing scheme. 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. 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.

MALCOLM ARTHUR LANYON, Deputy Commissioner for Corporate Services, NSW Police Force, sworn and examined

The CHAIR: I now welcome our first witness. Would you like to start by making a short opening statement? If so, please keep it to no more than a couple of minutes.

Deputy Commissioner LANYON: Thank you, Mr Chair. Thank you for the invitation to appear today. The NSW Police Force welcomes the opportunity to share the operational policing concerns that have given rise to the need for legislation to underpin a mandatory testing scheme. There are more than 17,400 sworn officers and more than 4,100 civilian staff in the NSW Police Force. It is a disturbing fact that New South Wales police officers are regularly assaulted in the course of their duties—around 2,537 assaults in 2019-20 according to Bureau of Crime Statistics and Research [BOCSAR]. During the same period, more than 490 officers were exposed to the bodily fluids of others. Not all of these were the result of deliberate third-party actions and not all would fall within the scope of the bill because they may not meet the risk threshold. However, we estimate around 210 of these 490 were deliberate. Also in 2019-20, we estimate that around 40 per cent of recorded contacts with third-party bodily fluids involved exposure to blood.

Waiting periods associated with self-testing of the police officer can lead to months of uncertainty, which can be enormously stressful and have lasting psychological impacts on the officer and their family. The officer may also have to manage the serious and debilitating side effects of preventative medication and manage the impact on their personal lives of having to prevent on-transmission to their partner. This is the context for the need for a scheme that supports the physical and psychological care and treatment of the exposed police officer. The objects of this Act are to provide for mandatory blood testing of a person in circumstances where a health, emergency or public sector worker, to whom this Act applies, comes into contact with the person's bodily fluid as a result of the person's deliberate action, and the worker is at risk of contracting a bloodborne disease as a result of the person's deliberate action; and to encourage health, emergency and public sector workers, to whom this Act applies, to seek medical advice and information about the risks of contracting a bloodborne disease while at work; and to protect and promote the health and wellbeing of health, emergency and public sector workers.

Existing processes ensure frontline workers receive the best possible care and treatment in the event that they have been exposed to bodily fluids during the course of their duties. However, the current arrangements do not provide for testing of the third party where there is a refusal to cooperate. This means exposed workers and their medical practitioner do not have access to information that might assist in their ongoing physical or psychological care. It is this information gap that the bill is addressing. As per NSW Health's policy directive for the management of healthcare workers potentially exposed to HIV and hepatitis, the test result of the source person is valuable information that will inform the risk assessment and medical advice that a medical practitioner is able to provide to a frontline worker. The NSW Police Force acknowledges the limitations of third-party testing, including negative test results due to window periods. However, we consider that the potential benefits for the worker justifies testing in the officer's ongoing treatment, including physical care, their psychological wellbeing and the provision of counselling or welfare support.

Similar schemes exist in Queensland, the Northern Territory, Western Australia, Victoria and South Australia. The scheme is not novel. The scheme as drafted in the bill is founded on the deliberate action of a third party. Accidental exposures are not captured. The NSW Police Force does not take lightly that this scheme overrides an individual's right to not consent to a medical procedure, but the right of the third party must be balanced against the rights of frontline workers who have been potentially put at risk by the third party's deliberate actions. We consider this bill appropriately balances an individual's rights and the rights of the frontline officer. Mandatory disease testing is only enlivened after the third party has committed a deliberate act and first refused to undergo voluntary testing to assist the care and treatment of the worker. A senior officer can only make an order if it is justified in all the circumstances.

Appropriate safeguards have been considered in the bill, including the ability to apply for a review to the Chief Health Officer, oversight by the Ombudsman and protection for what use can be made of the information derived from a test. Police, Corrections, and other emergency services and health workers stand on the front line day after day to protect and support the community. They deserve support and timely assistance when their courage results in actual or potential harm. Parliament has demonstrated its commitment to the health and wellbeing of those workers through this bill. The NSW Police Force supports the officers who serve within it and accordingly supports the bill as proposed.

The Hon. ANTHONY D'ADAM: Looking at the table at the end of the legislation, I wanted to clarify that that table is capable of being altered by executive order. Is that correct?

Deputy Commissioner LANYON: Sorry, the table at the end of the—

The Hon. ANTHONY D'ADAM: The table at the end.

Deputy Commissioner LANYON: Do you mind if I refer to the legislation?

The Hon. ANTHONY D'ADAM: Sure.

The Hon. TREVOR KHAN: That is the schedule of workers?

The Hon. ANTHONY D'ADAM: Yes, the schedule of workers.

Deputy Commissioner LANYON: Sorry, absolutely—the schedule is capable of being amended.

The Hon. ANTHONY D'ADAM: Why do you think it is necessary for the legislation to contain a delegation provision in section 34?

Deputy Commissioner LANYON: That was certainly seen by the legislators. In terms of a police officer, the reason that it has been brought to the senior officer level is that is an appropriate level consistent with other legislation. Certainly there would be police procedures put in place to ensure that the delegation did not go further than a senior officer.

The Hon. ANTHONY D'ADAM: The delegation refers to a class of employees that is dealt with by regulation, so presumably if there was a need for further delegation, it could be done by way of amending the schedule. It seems redundant.

Deputy Commissioner LANYON: Certainly that is the way the drafters have drafted the legislation, Mr D'Adam.

Mr DAVID SHOEBRIDGE: It is an unlimited power of delegation in section 34 of the bill, is it not?

Deputy Commissioner LANYON: As currently drafted?

Mr DAVID SHOEBRIDGE: Yes.

Deputy Commissioner LANYON: Yes.

Mr DAVID SHOEBRIDGE: So there would be nothing other than policy that would prevent this power being delegated even down to a constable level.

Deputy Commissioner LANYON: I think the legislation as drafted specifically refers to a senior officer, and a senior officer within the police force is a person of a commissioned officer rank.

Mr DAVID SHOEBRIDGE: Yes, but then it says:

> A senior officer may, in accordance with the regulations, delegate a function of the senior officer under this Act, other than this power of delegation, to a person of a class prescribed by the regulations.

If the regulations come out and provide a power of delegation, it could be exercised by pretty much any police officer.

Deputy Commissioner LANYON: I do not see that being the case, Mr Shoebridge, and I think as I have said before, as an organisation we would see a senior officer as a commissioned officer. We would certainly put policy in place were it not specific in the legislation.

Mr DAVID SHOEBRIDGE: But quite clearly there is a capacity to delegate below senior officers. That is obviously the purpose of delegation; it goes from a senior officer to a lower officer. You do not delegate up, you only delegate down. Is that correct?

Deputy Commissioner LANYON: Correct, but I think the word "senior officer" is specifically outlined in the legislation, so I do not quibble with your reading of the delegation powers.

The Hon. ANTHONY D'ADAM: On the term "deliberate", it seems that the intention is directed at situations where exposure is based on malicious intent. I wonder why the drafting instruction from the department is framed in that slightly broader term in terms of a deliberate act that does not preclude including occasions where there is not an assault or some form of malicious intent by the individual whose bodily fluids are being applied to the worker.

Deputy Commissioner LANYON: I suppose for the terms of the actual act which enlivens the provisions of the bill, the word "deliberate" or "intentional" can be synonymous, so the actual act itself is to be deliberate. Normally when there is an intent, it is an intent to carry something out, so there is a deliberate act that

does not require an intention by the person who conducts the deliberate act to actually transfer or impose a risk of a bloodborne virus [BBV].

The Hon. ANTHONY D'ADAM: Why have you chosen to take that wider approach in this legislation, given that the public advocacy around the bill is centred on occasions where there has been clear intent by an offender to weaponise bodily fluids against a worker?

Deputy Commissioner LANYON: There could be a number of examples in the real world where there could be a deliberate act by a person but the intent is not to deliberately inflict bodily fluids on a person. If you think about a situation where an offender has a knife, the offender may have self-harmed; the offender may injure the police officer with the knife. It is not necessarily the intention to transfer what is on that weapon, but the deliberate act is the person uses the knife against the police officer.

The Hon. TREVOR KHAN: Or themselves.

Deputy Commissioner LANYON: Or themselves.

Mr DAVID SHOEBRIDGE: So somebody could have self-harmed—slit their wrists—police attend and assist with paramedics, and then that would be a sufficiently deliberate action to ground a mandatory blood test.

Deputy Commissioner LANYON: No, it would not. They would take an action that was self-harm; they would need to conduct a deliberate act against the police officers to enliven the bill.

The Hon. TREVOR KHAN: That is not the evidence that we received yesterday from both the Public Service Association of NSW [PSA] and the Police Association of NSW.

Mr DAVID SHOEBRIDGE: There is nothing in the bill that says "deliberate act against police". "Against police" is a gloss you have put on them, but it does not appear in the bill.

Deputy Commissioner LANYON: I would suggest that the deliberate act that needs to enliven the provisions is the act against a police officer or an emergency services worker.

Mr DAVID SHOEBRIDGE: But it does not say that.

The Hon. TREVOR KHAN: For instance, the example that was used yesterday was somebody who secretes a syringe—the deliberate act being the hiding of the syringe. In the search of the cell, the prison officer receives a needlestick injury. You could substitute a police officer doing a search of a person who has hidden a syringe on themselves, but in that circumstance the view of the PSA and the Police Association of NSW—and I do not think I am being unfair—was that the deliberate act of hiding the syringe was sufficient to ground the operation of this scheme. Do you agree or disagree with that?

Deputy Commissioner LANYON: Can I go back to the self-harm analogy, Mr Khan?

The Hon. TREVOR KHAN: Yes, sure.

Deputy Commissioner LANYON: That is what really separates it from an accidental act. So there will be a number of occasions where a police officer will come in contact with blood or bodily fluids. It is not proposed that the bill or the Act is enlivened unless that is a deliberate act; in my mind, certainly not. If the person had taken self-harm against themselves, the act would then need to be that the person had blood on them as a result of that self-harm and then they made a deliberate action against a police officer or an emergency services worker.

Mr DAVID SHOEBRIDGE: But, Deputy Commissioner, clause 3 of the bill states:

> The objects of this Act are—
>
> (a) to provide for mandatory blood testing of a person in circumstances where—
>
> (i) a health, emergency or public sector worker to whom this Act applies comes into contact with the person's bodily fluid as a result of the person's deliberate action …
>
> (ii) the worker is at risk …

You add the gloss "deliberate action as against a police officer", or perhaps the more general term "as against a health emergency or public sector worker", but that is not found in the bill.

The Hon. TREVOR KHAN: I think it is unfair to describe it as a gloss, Mr Shoebridge.

Mr DAVID SHOEBRIDGE: I am not trying to be pejorative but, Deputy Commissioner, you add that qualification but the qualification is not found in the bill.

Deputy Commissioner LANYON: The way I envision the Act applying, and the way that I interpret the Act—and I certainly understand and, again, I am not being contrary to your reading of it—is that it is designed to separate a deliberate act as opposed to an accidental act. The fact that a person has blood on them could come from a number of different ways. There are a number of ways that a person can get blood on them. I see it as the deliberate act that is required to actually put that on there as opposed to an accidental exposure with a police officer.

The Hon. ANTHONY D'ADAM: You can see that this is a complex question that needs to be grappled with and yet the legislation envisages that this decision is going to be made at an inspector level. There is not crystal clear clarity around those judgements. The legislation has an appeals mechanism, but the way the legislation is currently framed that appeal will occur at a point after the sample has been taken. You can see that there is clearly a problem. Do you think it is appropriate that that kind of judgement should be done at a much more senior level or perhaps at a level that is independent from the organisation where the worker is employed?

Deputy Commissioner LANYON: No, I do not. I just believe that it is important that it is clear as to what is to be interpreted by that.

The CHAIR: For clarity, if the bill passes in the form that it is currently in or in an amended form, will those inspectors who have the delegation to make the decision be given training and information about what the bill will allow them to do with their operation and decision-making?

Deputy Commissioner LANYON: Yes, Mr Chair. There would be standard operating procedures and policies certainly constructed, which would be the normal course of our business. They would be conducted in accordance with our legal team and then there would be extensive training given to those senior officers so that they would understand the Act and the way that it was to be taken and interpreted.

The CHAIR: So a lot of the ambiguity that is being discussed around the table would be removed by that training?

Deputy Commissioner LANYON: Yes.

The Hon. TREVOR KHAN: Well, that invites a response, Chair. We have gone through a couple of years, for instance, with regard to strip searching where in budget estimates we were told that there were clear standard operating procedures. It is clear from the Law Enforcement Conduct Commission [LECC] that the perception of the senior officers with regard to the training was not the same as on the ground. I accept what Mr Lanyon says but—

The CHAIR: What I am asking is: At the senior officer level, will there be standing operating procedures? I am sure that there have been lessons learned from past evidence given to estimates or hearings. I am asking in this instance whether police will be developing training and special operating procedures, and the Deputy Commissioner has provided that response. That is what I was seeking.

The Hon. TREVOR KHAN: They are bound by the Act. They are not actually bound by the standard operating procedures.

The CHAIR: I understand that. That is why I asked whether they were receiving training around the Act as well. Mr Shoebridge, you can continue questioning.

Mr DAVID SHOEBRIDGE: Deputy Commissioner, what is the test that an inspector would have to consider before making this order?

Deputy Commissioner LANYON: The Act actually specifies the things that a senior officer must consider and they must consider that it is justified in all of the circumstances following those things.

Mr DAVID SHOEBRIDGE: Where do I find that in the bill?

Deputy Commissioner LANYON: It certainly sets out the grounds that a worker must put in their application for it. It certainly specifies what must be contained in an application. The senior officer must assess that application and any information that may be available to them, and then assess that in all of the circumstances.

Mr DAVID SHOEBRIDGE: I am just reading clause 10 (5) of the bill. I would invite you to have a look at it and tell me what it actually means. As I read clause 10 (5) there is not even a specific obligation for the senior officer to be satisfied that a deliberate action occurred. On a plain reading of clause 10 (5) it does not even have to involve a deliberate action. The objects are divorced from this section.

Deputy Commissioner LANYON: I would say clause 7 (b) clarifies that. They must be justified in all the reasons. A senior officer must make a determination on all of the reasons. The application has to specify why the worker is making that application, so that must be considered as part of all of the circumstances.

Mr DAVID SHOEBRIDGE: That is a heroic reading of clause 7 (b), Deputy Commissioner. I do not see the nexus between clause 7 (b) and clause 3 (a).

Deputy Commissioner LANYON: I certainly do. "Justified in all the circumstances" means that the senior officer must have considered all of the circumstances, which is the application, the Chief Health Officer's guidelines and any other matters that they deem relevant. I think the important word is the word "all".

Mr DAVID SHOEBRIDGE: But this allows for a whole lot of matters that are not considered in any guidelines issued by the Chief Health Officer and that are not set out in the bill. Any extraneous matter could be brought to the decision-making, such as: Getting the test may be perceived by the senior officer as assisting the psychological welfare of the person who was spat upon, even though the test itself will provide absolutely no medical assistance for the treatment of that officer.

Deputy Commissioner LANYON: I do not agree with that.

Mr DAVID SHOEBRIDGE: Did you hear the evidence yesterday from many of the medical experts, epidemiologists and professors whose expertise is in the transmission of HIV, hepatitis B and hepatitis C?

Deputy Commissioner LANYON: I did not hear all of the evidence. I certainly heard some of it.

Mr DAVID SHOEBRIDGE: I do not think it would be an unfair summary of it to say that every single medical expert—every single medical association—gave the same unambiguous evidence that you cannot catch a bloodborne virus, as defined in this bill, through spitting. You cannot.

The Hon. TREVOR KHAN: No.

The Hon. ROD ROBERTS: Point of order: That is not correct, Chair.

The CHAIR: I will uphold that point of order. Mr Shoebridge, there was discussion around whether there might be blood in the actual saliva.

Mr DAVID SHOEBRIDGE: I will be clear: You cannot contract a bloodborne virus through spitting alone. It cannot happen.

Deputy Commissioner LANYON: Through saliva alone? I agree with you.

Mr DAVID SHOEBRIDGE: Correct, and there is a vanishingly small likelihood of catching a bloodborne virus from spitting where that contains blood. That was the evidence.

The CHAIR: No. Mr Shoebridge, is there a question?

Mr DAVID SHOEBRIDGE: Other members may have a different take on it—

The Hon. TAYLOR MARTIN: Hang on. The Chair is speaking, Mr Shoebridge.

Mr DAVID SHOEBRIDGE: —but you cannot edit my questions.

The CHAIR: There was no question; that is my point. You have made a statement, but what is the question around that? What I recall the evidence being—it certainly appears on this side, as well—that is not exactly the evidence that was tendered.

Mr DAVID SHOEBRIDGE: Other people can put different propositions to this witness—

The Hon. TAYLOR MARTIN: Well, I will, actually. Is there a reason—

Mr DAVID SHOEBRIDGE: —but let me finish my question. Deputy Commissioner, given the uncontradicted medical evidence that there is an extraordinarily small likelihood of contracting a bloodborne virus through being spat upon with a mixture of saliva and blood—indeed, they could not identify a recorded instance where it happened—are you aware of that evidence and do you have any evidence to contradict it?

Deputy Commissioner LANYON: In response to your question, Mr Shoebridge, what I would say is that any risk will have a psychological impact on a police officer. If there is a risk that saliva mixed with blood can contain a bloodborne virus, that will have an impact on a police officer.

Mr DAVID SHOEBRIDGE: Are you telling police in these circumstances that you have reviewed the evidence, spoken to the medical experts and there is not a single recorded case of an emergency worker contracting one of these bloodborne viruses in those circumstances? Is that part of your pastoral care of police in these circumstances?

Deputy Commissioner LANYON: Most certainly. Our guidelines are emphatically clear that with saliva, urine and faeces on their own without any mixture of blood, there is no risk.

Mr DAVID SHOEBRIDGE: I appreciate this, Deputy Commissioner. If you could provide those guidelines on notice, that would be terrific. The second point is that even where saliva is mixed with blood, there is not a single identified case of an emergency services worker contracting one of these bloodborne viruses from coming into contact with saliva mixed with blood. Do you provide that information to your officers, to assist the psychological impact that they have?

Deputy Commissioner LANYON: We would certainly do that in conjunction with medical staff. The most appropriate way for us to provide that information is to take the officer and have them see a medical professional, who talks about that risk there. When we speak about the risk, part of what we are talking about is what operates in the mind of the police officer who has been spat on or who has had blood potentially put into their system. The evidence I heard yesterday from the medical staff was very compelling on a very cold front. Clean saliva, clean urine, clean faeces—I agree with that 100 per cent. In a real world situation, police will very rarely be confronted with just being spat on directly. It is more likely that it will be mixed with some form of blood or the police officers will be uncertain if it had some form of blood. The psychological harm that attaches to that act is what this bill helps to assist police officers with.

Mr DAVID SHOEBRIDGE: But that psychological harm comes as much from a misinformed, angry campaign from the likes of the Police Association, which is exaggerating the risk—

The CHAIR: Mr Shoebridge—

Mr DAVID SHOEBRIDGE: —as it does from the circumstances, Deputy Commissioner.

The CHAIR: Order! Mr Shoebridge—

Mr DAVID SHOEBRIDGE: Are you addressing that issue from the Police Association?

The Hon. TAYLOR MARTIN: You just hate cops, David.

The CHAIR: No, no. Mr Martin, please do not interject. Mr Shoebridge, yesterday I called you up on using language that was inflammatory. I ask you to just—

Mr DAVID SHOEBRIDGE: I stand by my question. I would like the Deputy Commissioner to answer it.

The CHAIR: I rule the question out of order.

The Hon. TAYLOR MARTIN: Mr Shoebridge started down this line of questioning on saliva. Mr Lanyon, you replied with an answer describing how blood can be mixed with saliva. I would like to hear a bit more around why we have used the definition of "bodily fluid", which does include substances like saliva. Saliva alone may not pose a terrible risk of bloodborne disease but surely there are many incidents where an officer cannot reasonably tell whether there is or is not blood mixed in with that saliva. What do you say to that? To add to Mr David Shoebridge's point, why are we concerned about saliva at all?

Deputy Commissioner LANYON: We are concerned about saliva because in realistic situations the circumstances will be that there will be blood mixed in it or there is certainly a risk that there is blood mixed within the saliva. I can give any number of circumstances where that would occur. For example, police officers attend an incident where two males have had a fight on a Friday night. One of them has been punched in the mouth. He will have blood in his mouth. He will not want the police to attend there. Most likely he may well spit on the police. If he does that, he will have blood in his saliva. I heard Mr Shoebridge's summary of the medical evidence. At no stage did I hear anyone say that there is no risk with blood in saliva. What operates in the mind of a police officer, irrespective of whether it is a low risk or not, is that through human nature they will believe that there is a risk if that is the case. It is very difficult for a police officer to determine whether there is blood in that saliva at the time.

The Hon. TAYLOR MARTIN: Will the operating procedures be developed in consultation with medical professionals or will it be developed solely by police?

Deputy Commissioner LANYON: There are Chief Health Officer guidelines, which will actually guide the way that the standard operating procedures govern. This obviously is a bill that has a medical context to it, so we will absolutely work with Health to ensure that our standard operating procedures reflect the best health advice.

The Hon. TAYLOR MARTIN: I want to go back to a point made earlier in the hearing about delegations. Why are delegations for the NSW Police Force at a lower rank than the other agencies that are outlined in this bill?

Deputy Commissioner LANYON: We obviously have, as you are aware, responsibility for a number of Acts. The senior officer level or a commissioned officer very much has delegation under a number of Acts,

including the Crimes (Forensic Procedures) Act, Law Enforcement (Powers and Responsibilities) Act and certain Roads and Transport Acts. So it is a very consistent level where decision-making is made within the police force.

The Hon. TAYLOR MARTIN: In your view, is there a risk that discretionary police powers will give rise to any individual bias?

Deputy Commissioner LANYON: There are a number of safeguards in the bill—certainly in terms of the potential to review a decision made by a senior officer. As I said, there are some very strict processes for workers wishing to apply and that senior officers, in considering all of the circumstances, must take into account.

The Hon. TAYLOR MARTIN: How can we be sure that this scheme provides that the police use of it is transparent and accountable?

Deputy Commissioner LANYON: The Act has oversighting responsibilities for the Ombudsman, who must report 12 months and then three years thereafter. Police are also under the responsibility of the Law Enforcement Conduct Commission.

The Hon. TAYLOR MARTIN: Could you explain a bit more on why it is necessary to allow police to use reasonable force under this bill?

Deputy Commissioner LANYON: Yes, certainly. The provisions in section 20 relate to a detained third party. They provide the authority for police to be able to transport the party using reasonable force to a place where a blood sample can be taken. They also provide the ability to assist a medical practitioner in taking that sample. I think it is important when you read section 20 that it cannot be read in isolation; it needs to be read in conjunction with section 19, which talks about the medical professional's responsibility to take a blood sample in accordance with ordinary medical procedures for taking that blood sample. The police officer will be operating under the direction of the medical practitioner and there will be circumstances where a medical practitioner will not be comfortable taking that blood sample depending on the behaviour of the third party.

The Hon. TAYLOR MARTIN: Fair enough. Would you explain a bit more why the bill requires the third party's action to be deliberate?

Deputy Commissioner LANYON: That is where the bill meets the actual, I suppose, balance between the rights of the third party and the worker. We are not looking to punish people who may well have blood on them and accidentally come in contact with the police officer and spread that blood or bodily fluid. This is really designed to take in the context where a person conducts a deliberate act against a police officer or an emergency services worker.

The Hon. TREVOR KHAN: Quite frankly, I am assuming that the bill is going to go through, so my questions are directed perhaps more to technical matters. I will go to clause 28 of the bill, which is the disclosure of information. You refer to that in your opening address. Tell me if I am wrong, but I take it that the disclosure of information provision—clause 28—deals with information that is essentially obtained by analysis of the blood sample. Is that right?

Deputy Commissioner LANYON: That is correct.

The Hon. TREVOR KHAN: All right. Can you point to anywhere in the bill—and I will be frank; I could have easily have missed it—that actually provides for what happens to the blood sample?

Deputy Commissioner LANYON: No, Mr Khan. There is no specific provision in the bill as to what happens to the blood sample.

The Hon. TREVOR KHAN: Is there any other piece of legislation that provides for the management of blood samples that have been forcefully taken—and we will take that as the case—or obligatorily or mandatorily taken from an accused person?

Deputy Commissioner LANYON: In terms of this bill, I would certainly defer to Health and would expect that the blood sample would be destroyed in accordance with their policy.

The Hon. TREVOR KHAN: Right. The issue I have got is this: Again, it is a long time ago, but I could envisage that some of my clients, who have had a bit of a dust-up with the coppers who have arrested them, could actually be involved in some pretty serious crime where DNA may be quite relevant to the investigation. I am wondering where are the provisions that ensure that the mandatorily acquired blood sample is dealt with for the purposes of this legislation as opposed to an investigation—whether it be an investigation relating to the dust-up or something else that my former punter might have been involved in.

Deputy Commissioner LANYON: Sorry, are you asking about the information derived from the sample or the sample itself?

The Hon. TREVOR KHAN: I am asking about the sample itself because I am very satisfied with regard to the information. It is the physical sample.

The Hon. CATHERINE CUSACK: Can it be used for another purpose?

The Hon. TREVOR KHAN: Yes.

Deputy Commissioner LANYON: In contradiction to a number of other mandatory blood samples that are taken which are normally used in connection with a criminal offence, this sample obviously is not. As I have said, there is no specific provision in the bill that talks about how to dispose of that blood sample. As I said before, I would certainly defer to Health for their policy on destruction. It is not something the police wish to have any contact with once it has been there. It is there for a specific purpose: to derive the information to assist the medical practitioner and to deal with the psychological welfare of the police officers.

The Hon. TREVOR KHAN: What is to stop a detective at Tamworth Police Station from suddenly deciding there is a blood sample there and executing a search warrant to seize the sample? Obviously they have to go through the processes of getting the search warrant, but it is a blood sample.

Deputy Commissioner LANYON: I would need to go through section 28 again, but the purpose of taking that blood sample is specifically in connection with this Act.

Mr DAVID SHOEBRIDGE: That is about the information though, is it not, Deputy Commissioner?

The Hon. TREVOR KHAN: Please take it on notice. Have a look at section 28 and see if there is some protection contained there with regard to that blood sample, because I do not think there is.

Deputy Commissioner LANYON: I am happy to take that on notice. I may have a view, but I am happy to take that on notice.

Mr DAVID SHOEBRIDGE: It is limited to the information. It does not reference the sample. That is the problem.

The Hon. TREVOR KHAN: Yesterday we heard about, and again today you have referred, to the Crimes (Forensic Procedures) Act. Is that right?

Deputy Commissioner LANYON: Correct.

The Hon. TREVOR KHAN: And the capacity of, say, a commissioned officer in circumstances to essentially make orders or directions with regard to the obtaining of forensics samples.

Deputy Commissioner LANYON: Certainly.

The Hon. TREVOR KHAN: That is the proposition that you are putting.

Deputy Commissioner LANYON: I am saying that there is a corollary between this Act and the Forensic Procedures Act in terms of the senior officer having power within both Acts.

The Hon. TREVOR KHAN: Alright. Am I right that, with regard to the senior officer exercising a power under the Crimes (Forensic Procedures) Act, that power is limited to non-intimate samples?

Mr DAVID SHOEBRIDGE: Non-intimate forensic procedure.

The Hon. TREVOR KHAN: Thanks, David.

Deputy Commissioner LANYON: You are correct.

The Hon. TREVOR KHAN: So buccal swabs and hair samples, I think, but not from a genital region, for instance—that style of thing.

Deputy Commissioner LANYON: Correct.

The Hon. TREVOR KHAN: Now if it is an intimate sample, that is, for instance from the genitalia or a blood sample, then an application has to be made to a court.

Deputy Commissioner LANYON: Correct. Under that Act, yes.

The Hon. TREVOR KHAN: Right. I suppose I am getting to this point: It is actually not a very good fit as a demonstration of a senior officer being capable of ordering the obtaining of the forensic sample, is it? Actually, it is the court that makes the decision under the forensic procedures Act, not the senior officer.

Deputy Commissioner LANYON: The senior officer can certainly make a determination, as you said, in terms of a non-intimate sample, so it shows that a senior officer can consider the circumstances and grant an order under that Act.

The Hon. TREVOR KHAN: I am not doubting but the Legislature has determined that it is appropriate where it is an intimate sample to require oversight by a third party. That is the essential position, is it not?

Deputy Commissioner LANYON: That is under that Act, but what I would say is it certainly—there could well be a difference drawn between that Act and this Act in the basis that the purpose for taking the blood sample or an intimate forensic procedure is for an ongoing criminal investigation.

The Hon. TREVOR KHAN: Indeed.

Deputy Commissioner LANYON: This Act is not seeking to use the information derived from the sample for anything but to assist the medical treatment and psychological welfare of the police officer.

The Hon. TREVOR KHAN: Indeed. Look, my final area of inquiry relates to this: Again, this could simply reflect my confusion. We referred earlier, I think, to essentially the taking of the punter in custody, I think, for the purposes of the forceful taking of a sample. Are you able to tell me the time frame that exists for the decision to mandatorily remove the sample?

Deputy Commissioner LANYON: I am sorry: Can you just clarify that question?

The Hon. TREVOR KHAN: My understanding is that an order, having been made—and I am taking this to be a non-detained person—they have 48 hours in which to provide the sample.

Deputy Commissioner LANYON: Correct.

The Hon. TREVOR KHAN: Right. In the case of a detained person, can that sample be sought in less than 48 hours, or does the 48 hours have to go by before force is used?

Deputy Commissioner LANYON: When a person is detained, this Act does not provide a specific provision to detain a person for the purpose of taking a sample.

The Hon. TREVOR KHAN: I accept that.

Deputy Commissioner LANYON: So it would be in accordance with a time-out under a usual investigation procedure because the person is in custody for a criminal offence. So, it would be in accordance with the times applicable to an investigation for a criminal offence.

Mr DAVID SHOEBRIDGE: But I suppose the question is this: If somebody has been served with a mandatory testing order and they say, "No", then is there a provision which would say, "Well, you've got 48 hours to change your mind and come up with this decision and if you haven't by the end of 48 hours, then we'll exercise the detention and arrest powers." Is that how it works?

Deputy Commissioner LANYON: No.

The CHAIR: Mr Shoebridge, I have got Ms Cusack and then Mr Roberts in line for questions. Ms Cusack?

The Hon. CATHERINE CUSACK: Thank you very much. Thank you very much for your attendance here today. I just wonder if you could tell us a bit more about the incidence. Is there an increase in the number of these forms of assault against police? Is there a trend at all? Do you have any details of, like, are they generally happening at night-time or during the day, and any additional data on that?

Deputy Commissioner LANYON: Yes, ma'am. Assaults against police are generally consistent over the past few years, so approximately 2,500 assaults on police during the year. In terms of potential incidents that would lead to the enlivenment of this Act, it would be spread between day and night. There would not be a way to say there is more incidents, day or night. Some of the examples that I have given you before are certainly likely to be more prevalent at night. You might say we have alcohol-fuelled violence where two people have a fight and there is blood put everywhere, but there are certain circumstances that happen, be it day time or be it night-time, that will happen there, so I think it would be difficult to say exactly whether it is more likely at night or day.

The Hon. CATHERINE CUSACK: Sure. The only reason that I am asking about the night is that I guess there are lots of services that are not operating at night—legal services, health services, those sorts of things. They are accessible but not in the way they are during the day. Can I just ask you about the process of what happens?

Deputy Commissioner LANYON: Sure.

The Hon. CATHERINE CUSACK: If somebody comes up—and this is a disgusting thing to do—and they do that to a police officer. What process flows from that?

Deputy Commissioner LANYON: In the normal circumstances at the moment, if a police officer was spat upon or had blood put upon them in general we would take them straight to the emergency ward to go and speak to a doctor and take medical advice on the risk and obviously the treatment that comes from there. We have standard procedures at the moment in the way that we manage someone, so supervisors will have responsibility in terms of how they deal with them. As an organisation we have very strong work health and safety responsibilities to ensure that we provide a safe environment for our police, so we have very strong procedures in terms of managing it.

The Hon. ANTHONY D'ADAM: Could I ask that those procedures be provided to the Committee?

Deputy Commissioner LANYON: If I can take that on notice, most certainly.

The Hon. CATHERINE CUSACK: That would be great. Thank you very much. In relation to the alleged offender, they are arrested. Is that correct?

Deputy Commissioner LANYON: Depending on the nature and how it occurs, ma'am. So, as I said, there can be accidental transfer of blood or bodily fluids, in which case there will be no offence. The vast majority of these will be a deliberate action, which will be from an assault. So, certainly they would be taken into custody, if that is the case.

Mr DAVID SHOEBRIDGE: And charged with assault?

The Hon. CATHERINE CUSACK: I have just another quick question, if I may.

Mr DAVID SHOEBRIDGE: And charged?

The CHAIR: Order!

Deputy Commissioner LANYON: Depending on the nature and the circumstances of the incident. Sorry, Chair.

The CHAIR: Oh, no. Mr Shoebridge—

The Hon. TAYLOR MARTIN: Has a habit.

The CHAIR: I ask Mr Shoebridge to observe the order that I have indicated, which is Ms Cusack and Mr Roberts, and then I will invite him or Mr D'Adam to ask further questions.

The Hon. CATHERINE CUSACK: Later on we are hearing from the Ombudsman's Office and I guess they will talk about their oversight role. I just wonder if the police have been engaged with the Ombudsman about some of the issues that they are concerned about in relation to their role in oversight and if you have any comment. Have you seen their submission?

Deputy Commissioner LANYON: No, I have not, ma'am, and I am not aware of any consultation between the police and the Ombudsman in terms of that oversight role at this stage.

The Hon. CATHERINE CUSACK: Okay. Thank you.

The CHAIR: Mr Roberts?

The Hon. ROD ROBERTS: Thank you, Chair. I have a number of questions, which comes as no surprise, Mr Lanyon, but I am mindful of the time so I will narrow them down. Yesterday we heard from doctors and professionals that sit in offices and at desks and they are not in the workplace that police officers are operating in, and they tell us that the police should not be concerned about urine and faeces. Could you give me a real-life example of where police should be concerned about urine and faeces?

Deputy Commissioner LANYON: Yes, certainly. Urine is probably a more complicated one to provide an example of, but there are a number of disgusting and degrading acts that happen, often when someone is in custody in a cell or in a holding dock. It is not unusual for them to deliberately defecate in there. It is not unusual for people to do self-harm in that cell, get blood mixed with the faeces, and throw that at police officers. That is not an unusual scenario in custody.

The Hon. ROD ROBERTS: And that has happened before, has it not?

Deputy Commissioner LANYON: Yes, it has.

The Hon. ROD ROBERTS: On a number of occasions. So, from that, there is a concern for police about faeces?

Deputy Commissioner LANYON: There certainly is when it is mixed with blood, Mr Roberts.

The Hon. ROD ROBERTS: Okay. Thank you. Let us clear up something that has been raised here this morning by Mr Shoebridge and that is section 34 of the Act about delegation. It talks about senior officers and he has homed in on police and senior officers there. But the schedule at the back of the Act specifies senior officers for a number of services. For example, it lists the senior office for Corrective Services as the Commissioner for Corrective Services. Do you think that the delegation provision of senior officer could be directed towards where the Corrective Services Commissioner may delegate to a governor of a particular jail?

Mr DAVID SHOEBRIDGE: Governor is already in the table.

The Hon. ROD ROBERTS: The terminology "senior officer" in this section does not just relate to police officers.

Deputy Commissioner LANYON: That is correct, Mr Roberts.

Mr DAVID SHOEBRIDGE: Point of order: It is unfortunate. We cannot misdirect this witness because a governor is already contained in the table. You could not delegate because the governor is already contained in the table. That confuses the witness.

The CHAIR: I will not rule on the point of order. I will just invite Mr Roberts to suggest another example.

The Hon. ROD ROBERTS: Okay. Well, the Secretary of Health, for example, may well choose to delegate their authority to the head of the Ambulance Service, for example, in terms of paramedics.

Deputy Commissioner LANYON: Correct.

The Hon. ROD ROBERTS: So, when we talk about "senior officer", the Act just does not refer to police?

Deputy Commissioner LANYON: No. The bill encompasses far more than just police officers.

The Hon. ROD ROBERTS: Sorry: the bill, not the Act. Forensic procedure policy, as discussed by my friend Mr Khan: He alluded to the fact that senior police officers do not have the authority to do that—to conduct the actual intimate examination.

Deputy Commissioner LANYON: Correct.

The Hon. ROD ROBERTS: But let us just clarify: That is much more intimate than just taking blood. So we could be looking at genital examination, vaginal swabs—all those type of things that would be best conducted by a doctor.

Deputy Commissioner LANYON: Absolutely. It is far broader than what is envisaged by this bill.

The Hon. ROD ROBERTS: Much broader, and much more invasive than the procedure of taking blood.

Deputy Commissioner LANYON: Correct.

The Hon. ROD ROBERTS: The disposal of the sample has been brought up. I do not expect you to make policy on the run, but could you envisage that the police force itself would have no objections if there was an amendment to the bill that, once that sample had served its purpose for this bill, it be disposed of completely?

Deputy Commissioner LANYON: I would have no objection, Mr Roberts. I think, as I have made very clear, the police support this bill because of the benefits it provides to the physical and psychological welfare of police. It is not intended to be used for any other purpose.

The Hon. TREVOR KHAN: And nor was I suggesting that there was such an intention. I am not suggesting that at all.

The Hon. ROD ROBERTS: No, there was no suggestion of that. I was just trying to extract from the witness whether there would be any objections, and clearly there are none—on his behalf at least anyway. In closing, how many police are disengaged from the service each year as a result of psychological injuries? Do you know off the top of your head? I know that is a fairly dicey question to ask.

Deputy Commissioner LANYON: I am more than happy to provide that on notice. What I can say is that an increasing proportion of our separations are psychological injuries, both in terms of number and obviously cost for the organisation. It is something that we are acutely aware of and, as a result, we have taken far greater steps to strengthen that because we are well and truly aware that it is an increasing problem for the organisation.

The Hon. ROD ROBERTS: And as an employer you have an obligation to provide the safest workplace you possibly can for your employees, is that correct?

Deputy Commissioner LANYON: Yes we do, both as an organisation and individually by virtue of my position as an officer under the work health and safety regulations.

The Hon. ANTHONY D'ADAM: I want to come back to this question about deliberate acts. Can I just clarify: It is your evidence that the senior officer needs to be satisfied that it was a deliberate act before they will make an order? Is that correct? Is that your evidence?

Deputy Commissioner LANYON: The bill is only enlivened by a deliberate act. The application has to specify what the worker foresees as the deliberate act that has taken place, and the senior officer must consider all of the circumstances. So I certainly envisage they must be satisfied that it is a deliberate act.

The Hon. ANTHONY D'ADAM: How do they satisfy themselves that it is a deliberate act?

Deputy Commissioner LANYON: Based on the circumstances that are outlined in the application and any other circumstances that may assist that.

The Hon. ANTHONY D'ADAM: So they have got an application, it has been prepared by the affected worker—that is the primary information that they are relying on in making that determination?

Deputy Commissioner LANYON: Correct.

The Hon. ANTHONY D'ADAM: How do they satisfy themselves that that is actually a correct assessment? Obviously, the worker has an interest in the application being made, so there may be circumstances where the worker's recollection of what occurred might be influenced by their concern about their own health position. So how does the decision-maker, the senior officer, satisfy themselves?

Deputy Commissioner LANYON: What you are talking about is a minute-by-minute, day-by-day thing for a normal police officer. Police officers, police supervisors, police senior officers are very much used to looking at circumstances of an incident and deciding whether it is deliberate. We spoke before about assaults and how we satisfy that there are sufficient grounds to actually arrest someone for an assault. What we are talking about here is a set of circumstances that is very native for a police officer in their day-to-day role. I do not envisage that a senior officer would have any difficulty in deciding whether something is a deliberate act.

The Hon. ANTHONY D'ADAM: There is nothing in the Act that specifies any other source of information in corroborating the information that is in the application, is there?

Deputy Commissioner LANYON: Nothing specifically in the Act, but it does talk about, from memory, "or other information".

The Hon. ANTHONY D'ADAM: Is it possible that a decision-maker might have some doubt about whether it was a deliberate act but still they would, in the circumstances, feel that it is justified to make an order?

Deputy Commissioner LANYON: No, I do not agree with that at all. The senior officer has the ability to refuse the application if they are not satisfied in normal circumstances that it is justified.

The Hon. ANTHONY D'ADAM: There is no specification about the standard of satisfaction. "Satisfaction" is not even used in the provisions of section (5) (b); they just have to "consider". So there is no standard in how comfortable they are about the facts being sufficient for them to make the order, is there?

Deputy Commissioner LANYON: I disagree with that. I think the words "justified in all the circumstances" mean that they must be satisfied that there are sufficient circumstances to grant the order.

The Hon. ANTHONY D'ADAM: They must be satisfied that it was a deliberate act?

Deputy Commissioner LANYON: That is one of the circumstances in the application, so I would believe they would be satisfied that it was a deliberate act.

The Hon. ANTHONY D'ADAM: So if there is any doubt, they cannot make the order?

Deputy Commissioner LANYON: The bill is enlivened by a deliberate act, so it is something that fundamentally—

The Hon. ANTHONY D'ADAM: My question is about whether the extent of the doubt—

The CHAIR: Order! Mr D'Adam—

The Hon. ANTHONY D'ADAM: I am just clarifying my question.

The CHAIR: You have asked the question, the witness has started commencing his answer. Allow him to finish before you clarify if he is not providing the answer that you seek.

Deputy Commissioner LANYON: The application requires that the worker outlines the basis for the application, including the nature of the deliberate act. The senior officer must consider all of the circumstances and, before granting an order, be satisfied that the order is justified in all of the circumstances. So that says to me that a senior officer must consider that it was a deliberate act.

The Hon. ANTHONY D'ADAM: But if there is doubt, any doubt, can they make the order?

Deputy Commissioner LANYON: "Justified in all the circumstances", so I would suggest that if there is doubt they will refuse the order.

The Hon. ANTHONY D'ADAM: If there is doubt they will refuse the order. Is that is the standard that will be applied in the guidelines that are provided to senior officers making the decision by the department?

Deputy Commissioner LANYON: No, the test is that they must believe it is justified in all the circumstances. What we are trying to do is to create words here to find a way not to. They have to be satisfied at a certain standard, not the opposite.

Mr DAVID SHOEBRIDGE: What standard?

Deputy Commissioner LANYON: Justified in all the circumstances.

Mr DAVID SHOEBRIDGE: That is not a standard.

The Hon. ANTHONY D'ADAM: Is it possible that in this test—"justified in all the circumstances"—and there is a situation where there is clearly blood-to-blood exposure so there is an elevated risk posed to the officer or worker concerned and there is some doubt about whether it was a deliberate act, do you think in those circumstances, in applying this "justified in all the circumstances" test, the officer might still be justified in making the order?

Deputy Commissioner LANYON: The senior officer needs to be justified in all the circumstances that the making of the order is required. So they would have to take into account all of those things in getting there. It is not a matter of either/or, it is a matter of considering each of those circumstances as they work through it.

The Hon. ANTHONY D'ADAM: So every circumstance needs to be satisfied in order for the order to be made. Is that your evidence?

Deputy Commissioner LANYON: I think I have given evidence earlier on to say the deliberate act is fundamental to enlivening the bill.

The Hon. ROD ROBERTS: I have two questions in clarification. If you have the bill in front of you, and I am sure you do—

Deputy Commissioner LANYON: I do.

The Hon. ROD ROBERTS: On page 22, which is the schedule that I alluded to previously, it was suggested that I may have misled you. Let us correct the record completely. I suggest that Mr Shoebridge may have misled people. For Corrections officers, the senior officer is the commissioner of Corrective Services. Where Mr Shoebridge may have been confused is that the governor of a managed correctional centre is the senior officer. My proposition that the commissioner of Corrective Services is the senior officer was, in fact, correct.

Deputy Commissioner LANYON: Correct, Mr Roberts.

The Hon. ROD ROBERTS: One final question arising from Mr D'Adam's questions. If a senior police officer—and let us sidestep away from this bill for a moment, but this bill would encompass it—abuses his position and oversteps the mark or steps outside guidelines, policy and/or legislation, what is the position there?

Deputy Commissioner LANYON: In terms of a senior officer, there is already a misconduct framework within the police force, and there is a very strong complaint process that follows through. I think I indicated before that the police are oversighted by the Law Enforcement Conduct Commission [LECC], as well as the bill being oversighted by the Ombudsman. If I could just go further to Mr D'Adam's question before. He spoke about the worker not embellishing but certainly putting a larger spin on what the deliberate nature of the act is. There is a specific provision within the bill which talks about an offence for a worker who provides false or misleading information in that application. So the bill very much protects against that circumstance.

The Hon. ANTHONY D'ADAM: Will there be an audit process? Is that a matter that will be the subject of some ex post facto evaluation or assessment?

Deputy Commissioner LANYON: The bill already has that in it with the Ombudsman's oversight function.

Mr DAVID SHOEBRIDGE: What is required in the mandatory testing order application is a statement that, in the opinion of the worker, the contact with the third party's bodily fluid was the result of a deliberate action.

Deputy Commissioner LANYON: Correct.

Mr DAVID SHOEBRIDGE: So the decision-maker is reliant upon the opinion of the worker.

Deputy Commissioner LANYON: Correct.

Mr DAVID SHOEBRIDGE: And indeed the bill itself does not actually require satisfaction that there was a deliberate act, because the reference to the requirement of a deliberate action is only contained in the objects of the Act, is it not?

Deputy Commissioner LANYON: That is correct.

Mr DAVID SHOEBRIDGE: Are you aware that you have to have regard to the objects of the Act, but that they are not the operative provisions?

Deputy Commissioner LANYON: Yes, most certainly.

Mr DAVID SHOEBRIDGE: A decision-maker could see the opinion, not be so satisfied about the opinion but, for unrelated reasons, think that it was justified in the circumstances could they not, even without a deliberate act.

Deputy Commissioner LANYON: I think, Mr Shoebridge, what is being contemplated when you talk about the opinion of an officer, that is what happens every day when you arrest someone for an assault. The officer forms the opinion that the action was worthy of charging someone with an assault. That opinion is not something that is unusual and not something that is not within law itself. It is the observation of the officer; that is really what you are asking for.

The CHAIR: And with that—

Mr DAVID SHOEBRIDGE: But before actions are taken against people, you do not go to jail on the opinion of a police officer. Someone actually tests the facts at some point in all of that.

The CHAIR: Order! I am speaking. Please have a little bit of respect for the Chair. Thank you for attending the hearing, Deputy Commissioner. The Committee has resolved that answers to questions you have taken on notice will be returned within 14 days. The secretariat will contact you in relation to the questions that you have taken on notice. Thank you for your appearance today.

Deputy Commissioner LANYON: Thank you, Mr Chair. Thank you, Committee.

(The witness withdrew.)

MICHELLE CRETIKOS, Executive Director, COVID-19 Response, Population and Public Health, NSW Health, affirmed and examined

MARK FOLLETT, Acting Executive Director, Policy, Reform and Legislation, Department of Communities and Justice, affirmed and examined

GAYLE ROBSON, Chief of Staff, Office of the Commissioner, Corrective Services NSW, Department of Communities and Justice, affirmed and examined

CRAIG SMITH, Director, Western Region, Corrective Services NSW, sworn and examined

The CHAIR: Welcome back to the second session of today's hearing. All of the witnesses are invited to make an opening statement.

Mr SMITH: Thank you for the opportunity to speak about this important piece of legislation. I have been a correctional officer for the last 20 years, having worked in a variety of correctional centres in a number of frontline roles. Most people do not understand what occurs behind the walls of a correctional centre. Mostly, the day-to-day operations run smoothly due to the great work staff do in managing what can be a volatile environment with unpredictable inmates. But correctional officers also respond to incidents that see transmission of bodily fluids; that includes spitting, biting and having urine and faeces thrown on them. For example, staff have to deal with inmates biting them whilst they are bleeding from a face wound. That obviously places the staff member at risk of transmission of bloodborne diseases. We do not know what diseases inmates have. This is part of what we do and we treat inmates all the same, and we use the premise of universal precautions when dealing with them. Staff do not care what diseases inmates have. We deal with individuals on a day-to-day basis and to the best of our ability.

The effects on a staff member who has been exposed to bodily fluids can be much greater than anyone can anticipate. It causes extreme distress to the staff member both physically and mentally. Staff are required to participate in numerous tests for bloodborne diseases, each with extensive wait times. Waiting for the results and the what-ifs causes psychological distress; it affects relationships, partners, children and colleagues. We are left not wanting to be intimate with people. We fear passing on the disease, petrified that a small cut that has seeped onto a child might result in a lifelong limiting illness. Waiting months to determine if we have an illness feels like an eternity that over that time we just assume the worst. Mandatory disease testing can assist in reducing the psychological distress by reducing the length of waiting considerably. Although staff may still have to wait to get cleared medically, I can assure you the relief that could be offered knowing that an inmate does not have any disease would be life-changing. Thank you.

The CHAIR: Ms Robson?

Ms ROBSON: Nothing from me, thank you.

The CHAIR: Dr Cretikos?

Dr CRETIKOS: Thank you for asking me to speak with you today about the Mandatory Disease Testing Bill. I will briefly outline NSW Health's current approach to the management of this issue and then I will be happy to take the Committee's specific questions on the bill. First, NSW Health recognises that occupational exposure to blood and body fluids can be extremely stressful for the worker involved and needs to be managed in an expert and timely way. NSW Health has a well-established approach to the management of staff who have been exposed to blood and body fluids. The potential for exposure to bloodborne viruses is a significant occupational health and safety matter for NSW Health and preventative measures are embedded into everyday practice. In NSW Health the Blood and Body Fluid Exposure Phoneline is a seven-day-a-week information support and referral service for New South Wales-based healthcare workers who sustain needlestick injuries and other blood or body fluid exposures during their work. There is also an escalation pathway within the health service to ensure timely access to support, assessment, management and treatment if required.

NSW Health's evidence-based procedures are described in the policy directive *HIV, Hepatitis B and Hepatitis C – Management of Health Care Workers Potentially Exposed*, which is mandatory for all NSW Health facilities. Under this directive the risk of transmission of a bloodborne virus is assessed based on the type of body fluid, whether it contained blood and whether it contacted intact skin, mucosal surfaces, broken skin or a penetrating injury. There are many circumstances involving bodily fluid exposure where there is no risk of transmission. Contact with body fluid against intact skin is not considered an injury. A superficial injury such as exposure through broken skin or mucosal surfaces, such as a splash to the eye or mouth, is considered a low risk exposure. Situations where there may be a risk of transmission normally involve blood coming into contact with sharps such as needles containing a person's blood, or open wounds.

Even then, the risk of transmission is low. It is important to recognise that the bloodborne virus status of a person that a worker has been exposed to may not affect the immediate management of the exposed person. Precautionary measures such as post-exposure prophylaxis must be taken immediately in the situation of a higher risk exposure and injury. The bloodborne virus status of the source cannot be known confidently in this time frame. Even if the recent results of testing for bloodborne viruses are known, the window period for detection of infection may still affect management and require immediate treatment until such time as further information can be obtained. In all cases of occupational exposure to bodily fluids, it is important that the affected worker has rapid access to an appropriate health professional with experience in managing bloodborne viruses, in order for a careful risk assessment to be conducted and appropriate management immediately instituted.

It is NSW Health's experience that early access to an appropriately skilled and experienced practitioner is important not only for managing the risk but also to alleviate the anxiety of those affected. NSW Health is responsible for increasing access to care and testing for bloodborne viruses, as well as activities to prevent and reduce transmission, stigmatisation and impact of bloodborne viruses on the New South Wales community. Stigma and discrimination can be barriers to prevention, testing and treatment initiation, and retention in health care settings. In our experience, negative perceptions of health services and experiences of stigma and discrimination may result in reduced access to testing, reduced engagement with treatment and poor retention in treatment.

Reducing stigma and discrimination is a key priority in NSW Health strategies for bloodborne viruses, including HIV and viral hepatitis. New South Wales is recognised as a world leader in implementing strategies to reduce the impact of bloodborne viruses in our community. This has been achieved by NSW Health working in close partnership with researchers, clinicians and community organisations over the last 35 years, implementing a range of initiatives to promote evidence-based awareness about bloodborne viruses and to reduce stigma and discrimination. I am aware that many of the partners and stakeholders that NSW Health works closely with have made submissions and spoken to this inquiry about this bill. Many of these partners have expressed a range of ongoing concerns.

Common themes from any of these partners that they believe the bill may exacerbate stigma and discrimination; does not reduce the risk to frontline workers; does not ensure timely access to appropriate medical care to achieve accurate assessment of the actual risk of bloodborne virus transmission and early management; and does not reflect the current evidence on bloodborne virus transmission and prevention. There are also concerns in relation to the proportionality of the approach for those under 18 years; a concern for safety in the situation where an order requires the application of force to obtain a blood test; and a concern that a blood test may still not be able to be obtained as an outcome of this extensive process. Thank you for inviting me here today. I am happy to help.

The CHAIR: Thank you very much for those opening statements. We will now move to questioning. I will give Mr Shoebridge the opportunity to open the questions.

Mr DAVID SHOEBRIDGE: Thanks, Mr Chair. Thank you all for your attendance today and your submissions. My first question is to Mr Smith and Ms Robson. First of all, Ms Robson, I am not quite sure what your position is and what your role is as chief of staff of the commissioner. What does that mean organisationally?

Ms ROBSON: In relation in particular to this bill, I have been involved with other colleagues on a working party in the development of it. I also play a key role in connecting Corrective Services NSW with our human resources [HR] business partner and the importance of work health and safety and occupational health and safety requirements to this issue.

Mr DAVID SHOEBRIDGE: What is the HR business partner?

Ms ROBSON: The HR business partner is simply a model within our organisation around how corporate services are provided. Obviously, blood spills raise work health and safety concerns for us. Part of my remit is to work with the human resources business partner in facilitating support and advice on those issues.

Mr DAVID SHOEBRIDGE: Alright. Mr Smith or Ms Robson, are you aware of the NSW Health procedures document dealing with HIV, hep B and hep C? Have you read it and familiarised yourself with it?

Mr SMITH: No, I have not had a great look over it. I actually tried to find a lot of the information. I found when I actually started looking I found numerous—but, yes. No, I have not looked over it, but we have got our other one.

Ms ROBSON: Information that is available for our staff and for our managers—there is a document that has been developed specifically around correctional officers and bloodborne viruses. It is used in correctional jurisdictions right across Australia. It was prepared by the Australasian Society of HIV Medicine.

Mr DAVID SHOEBRIDGE: Alright. Do you agree with the position adopted by NSW Health in its health procedures? They have a number of tables. They talk about the risk of transmission of bloodborne viruses from an infectious bodily fluid by injury type. It says:

Injury with no risk

- Skin not breached
- Contact of body fluid with intact skin
- Needle (or other sharp object) not used on a patient before injury

Do you accept that is an injury with no risk, as set out by NSW Health?

Ms ROBSON: We would certainly take on board health advice. We are not health experts and we would simply accept the advice around transmission risks that Health provides.

Mr DAVID SHOEBRIDGE: You say "would". Have you accepted that advice and is that the clear, unambiguous information you give to prison officers?

Ms ROBSON: Without re-familiarising myself word for word with the document that I have—it does sound very similar. Where there are not cuts or scratches on our officers, that is low risk, yes.

Mr DAVID SHOEBRIDGE: No, no. There are three categories in the NSW Health document. There is higher risk injury and lower risk injury. I was putting to you the "no risk" category. You said "low risk". I am asking you whether or not you accept the NSW Health position that this is injury with no risk.

Ms ROBSON: I am not a health expert and I would simply have to take on board what the health advice is.

Mr DAVID SHOEBRIDGE: So, you would accept that if NSW Health adopts that position, that position and that advice should be accepted by Corrective Services?

Ms ROBSON: Yes, as a health advice.

Mr DAVID SHOEBRIDGE: Alright.

The CHAIR: Mr Shoebridge, I am sorry. I would ask you to ask questions, not pose propositions and then ask whether they agree or not.

Mr DAVID SHOEBRIDGE: I am sorry, Mr Chair. I will ask my questions as I see fit and I will not have them directed by you.

The CHAIR: In that case, I will rule them out of order.

Mr DAVID SHOEBRIDGE: I challenge that. You cannot do that.

The Hon. TREVOR KHAN: Look, I do not want this to get out of control. You know I am quite often down Mr Shoebridge's throat with regard to his questions, but I have got to say that I do not think the proposition he was putting offends any standing order or any rule in the operation of this Committee. I do not want to see this thing go off the rails.

The CHAIR: I just ask that Mr Shoebridge observes procedural fairness and gives the witnesses an opportunity to answer a question, other than a "yes" or a "no" answer.

Mr DAVID SHOEBRIDGE: Okay, noted. Ms Robson or Mr Smith, are you also aware of the NSW Health advice contained in its procedures on HIV, hepatitis B and hepatitis C, where it is speaking to body fluids and risk for bloodborne virus transmission? They provide this in relation to the level of risk: they categorise the level of risk as "not infectious" unless visibly bloodstained. They say that in relation to nasal secretions, non-dentistry saliva, sputum, stool, sweat and tears. It is unambiguous that those bodily fluids are not infectious unless visibly bloodstained. Is that the unambiguous, clear and calming advice that you give to corrective officers?

Mr SMITH: The advice that we get—I can tell you that I have not seen that health department document, but I can tell you that the nurses at a jail will say to the officer, "Head straight to the nearest hospital and get a blood test because you need to be checked because you may have caught something." Yes, there is obviously a document that says that, but when you are at a centre, the nurses or the doctor who are on duty will actually send you straight to a hospital. I do agree that that is their document and that is what it says on it, but on the other side of that what happens in real life is you are sent straight to a hospital.

Mr DAVID SHOEBRIDGE: But we heard from NSW Health that one of the key ways of dealing with anxiety and addressing the very real concerns that prison officers would have is not just to send them off to a nurse

but to ensure that they get expert, timely and appropriately skilled practitioners who are fully versed in infectious diseases to alleviate the concerns of the person who has been exposed. You do not seem to have that process in place.

Mr SMITH: What I say is, as a correctional centre, we do, but you are immediately sent to a medical practitioner who will say to you, "Go and wait at the emergency department at a hospital and then get tested there and then go back to that same area and get tested again." Full support is given, but the health advice is that, yes, they are low-risk but they are still sent for all the same tests whether it be low-risk or not.

Mr DAVID SHOEBRIDGE: I am asking you again whether or not Corrective Services, in its duty of care in dealing with the concerns by corrective officers, accepts NSW Health's position that what you need to provide is expert, timely and appropriately skilled professional advice—people who know their stuff. Not just off to the GP or off to the local emergency but appropriately skilled. Why do you not have that advice available on hand?

Ms ROBSON: One of the things coming out of the bill is the need for us to provide more skilled counselling. That will be a requirement before an officer is able to make an application for a mandatory disease testing order. At the moment, as Mr Smith has indicated, our advice—and it is based on the information in the document I referred to earlier—is that staff are sent to medical professionals, be that their own doctor or emergency departments and then the information that is required is there. Corrective Services is not the provider of medical services. We do not provide medical services to people in custody; that is provided by Justice Health. We are not medical providers. We certainly refer our staff to appropriate medical support when it is required.

Mr DAVID SHOEBRIDGE: Ms Robson, you send them off to their local GP. But if you had done the most basic review and research of what is required to assist your own staff—and you say that occupational health and safety and the concerns of your staff are priority—you would have realised you should be ensuring that they get in contact with expert, timely and appropriately skilled professional advice and you are not doing that. Why not?

Ms ROBSON: Our advice through the expert information that was provided to correctional jurisdictions all across Australia is that they should go and see their GP or the emergency department. The organisation that was referred to, being the Blood and Bodily Fluid Exposure Phoneline, is referenced in this document as an organisation to contact; however, it also says it is recommended that officers contact their local emergency department following an exposure to blood or bodily fluids for advice.

The CHAIR: Can I seek a few points of clarification? Mr Smith, you referenced earlier that what occurs to an officer who has had exposure to bodily fluids is that they would go and see the nurse who is on duty and would often be referred to hospital or a doctor. In those instances is it usual that you would know, for example, if you were spat on, that it was saliva only? Is it possible that you could suspect that there might be traces of blood within that saliva and that would not be determinable at the time at which you are given the advice to go to the hospital?

Mr SMITH: Generally it depends on where you are spat at. If you are spat straight in the face, it has generally gone in your mouth or in your nose so you may not always see it. I have been spat on several times and you can generally see if it has got blood in it or if it is just saliva. The best advice I give to junior staff where I have been coming through is to get checked anyway because you will never know. You want to put your own mind at rest around whether you have caught something or not. But we try again to give a calming influence. "Here are the details around people you can call"—each provider and stuff like that. But generally we do not say, "Look, we think you have got something." It starts with, "Look, it was a very minor issue." We give a calming influence, support people and go with them. Generally we drive them to the hospital. Sometimes they will refuse and say they will take themselves. But the support is there. Yes, you can tell generally if you have got blood or just spit on you.

The Hon. TREVOR KHAN: Mr Smith, I am not talking about needlestick injuries so let us put those aside. In these spitting incidents, are you aware of how many of those spitting incidents have resulted in the infection of a prison officer?

Mr SMITH: No, I am not. Sorry. I could try to find out, but I am not.

The Hon. TREVOR KHAN: It seems to me that the basis of this bill is that there is an identifiable danger. What seems to have been lacking is really any evidence of the infection of prison officers from the incidents that are most commonly described and that is spitting. I accept that, if there is blood, I would want to test too, but I am just interested in this question. There is a paucity of evidence of effect. Ms Robson, are you able to assist?

Ms ROBSON: Certainly we do not have specific data on contraction and there may be some—

The Hon. TREVOR KHAN: Any data?

Ms ROBSON: No, we have data on the number of bodily fluid exposures and I can certainly take that—

The Hon. TREVOR KHAN: Well, Ms Robson, that is the problem. I have seen a lot of evidence of incidents where officers clearly, whether they be prison or police officers, have been the subject of really horrendous physical assaults through such things as spitting, but that is where the information stops. I am not condoning it in any way and, as I have said to other witnesses, I had a former client who spat right in my face because he was pretty uncomfortable with my lack of regard for what he was asking me to do. I did not like that. I am sympathetic to that extent, but it seems to me that I am still waiting for the killer punch and I am not getting it.

Ms ROBSON: I think there would also be some issues in accessing information. Staff are not actually required to declare whether they have contracted an illness.

The Hon. TREVOR KHAN: They will have put in a workers compensation claim.

Mr DAVID SHOEBRIDGE: They must have.

Ms ROBSON: They may have put in a workers comp claim mainly in relation to the exposure. I can take that on notice and see if we have any data.

The Hon. TREVOR KHAN: I would invite you to do that.

Ms ROBSON: But I also think what is important to remember is the purpose behind the bill is to provide some information and advice to officers, to assist them in treatment and to alleviate some of the psychological distress.

The Hon. TREVOR KHAN: And I accept that. The bill is going to go through, as night follows day, I think, from my perspective, but I am just concerned that the purpose of this exercise of this Committee is to be presented with evidence that underpins why we are doing something. I am going to do it because my party will tell me to do it, to be frank, but I am just left with this lacuna—big black hole—of information that underpins the bill.

Mr DAVID SHOEBRIDGE: Does NSW Health have any?

The Hon. TREVOR KHAN: Yeah—I would be happy with that.

The CHAIR: Before we do that, I have just one follow-up question for Mr Smith and then I will pass the questioning over. Mr Smith—and perhaps we can help to fill Mr Khan's big black hole of information—but as you are a serving corrective officer I would be interested in your personal experience. Can you provide to the Committee what it is like as a front-line officer to have exposure and what it is like to wait for a test, and what that does to your psychological state of mind, and how a mandatory test in that situation would either help or hinder your recovery?

Mr SMITH: Yes. So my career has spanned the whole of New South Wales. I have worked from Broken Hill to Kempsey to Wellington and to being the governor of the Metropolitan Reception and Remand Centre [MRRC] in Sydney. Probably when I was in my more junior ranks I was an immediate action team [IAT] senior which was spat on quite regularly because generally we would be called to deal with the worst of the worst. And, yes, it is horrific. If you get blood on you, particularly in things—you are not even thinking. You run into a fight and you are trying to stop two inmates actually bashing each other. Before you know it you are in amongst it and you have got blood all over you. You just did not even mean to do it but you are trying to stop two inmates really hurting each other and then you sort of have got to go home and then you think, "How am my going to tell my wife this?"

I am very lucky: My wife is in the job as well, so she understands that side of it. But I can imagine and I have seen. Other people that I know had a pregnant wife and did not want to tell his wife because he was so horrified it could cause marriage breakdown. It was horrific. He thought he was bringing something home. But from my point of view most of my time is out at Dubbo. You would have to go to the hospital. You were classed as low-level when you went into the emergency department so you would sit in a seat for four hours. You would go in and actually then get your test and then you would be told come back. You would get, obviously, your results—three months, six months. I am not sure if that is actually still the exact time frame but it was three and six when I was doing it. To be honest with you, it was horrific. It is not so much that you really believe you think you have it; you just do not know.

You are more about the stress of it and you start to think, "Are people looking at me when I am going to work? Do people think I have something as well?" You tend to stay away from everybody. You do not want to share a cup of tea with somebody. You do not want to go and sit with people that you would normally go and sit with. It changes you for six months and it is genuine relief when you know that is clear. That is one thing from my point of view. The really big thing is I have seen grown men cry just thinking, "I've got three young kids and I'm never going to see them again." That may be up in the air but mental fatigue will do that to you, especially in our environment. I agree that the risks are low but it is that maybe.

The Hon. TREVOR KHAN: Sorry. Can I ask a follow-up question?

The CHAIR: Yes, you can.

The Hon. TREVOR KHAN: Dr Cretikos, you may or may not be able to answer this. Presuming that a mandatory testing regime is put in place, if a worker—sorry, if a third party has been tested and the test comes back negative to HIV, et cetera, what impact will that have on the testing regime that the officer will go through post the outcome of that test?

Mr DAVID SHOEBRIDGE: Treatment?

The Hon. TREVOR KHAN: Yes, and the like.

Dr CRETIKOS: So, I am not an infectious disease expert. I am a public health doctor.

The Hon. TREVOR KHAN: That is all right.

Dr CRETIKOS: But based on the policy the treatment would be dependent on the consideration of the injury and the consideration of the type of exposure as well as a consideration of other risk factors that may or may not be known about the third party's source and likely risk.

The Hon. TREVOR KHAN: You see the problem is, is it not, that a negative test from the third party, if I can call him or her that, is one indicator but only one indicator of the possibility of infection, is it not? That is to say you cannot be certain that the test is actually produced an accurate result.

Dr CRETIKOS: So, in the instance of a high-risk exposure directly to blood with a penetrating injury, it is likely that the treatment would still continue until such time as a definitive test result can be obtained—usually six to 12 weeks later.

The Hon. TREVOR KHAN: Of the?

Dr CRETIKOS: On the person who has been exposed.

The Hon. TREVOR KHAN: On the person who has been exposed.

The CHAIR: Accepting that, though, I will just turn back to Mr Smith. Would there be a level of relief knowing that the third party, having been tested, has returned a negative result for those bloodborne diseases to the officer?

Mr SMITH: Yes, definitely. I have actually had an inmate tell me they got something when they have spat on me. So later on, when they have calmed down and everything is settled, they have said, "Look, I've had hep C. Sorry." As soon as I knew that, I was like, "All right. At least I know." We went away. Now, it was only a small mark on my shirt so I was not actually worried but it was spit. It was not blood, but, it is a level of relief. It is definitely a relief when you know what they have.

The CHAIR: With the psychological impacts in the role, would that help you to—do you envisage that it would help your recovery?

Mr SMITH: Yes. Yeah, definitely.

The CHAIR: Thank you. I will pass questioning now to Mr D'Adam.

The Hon. ANTHONY D'ADAM: I direct some questions to Dr Cretikos. Can I just clarify the capacity in which you are here today? You are here representing NSW Health or the Chief Health Officer?

Dr CRETIKOS: The NSW Ministry of Health.

The Hon. ANTHONY D'ADAM: The Ministry of Health. So the statement that you made represents the position of the Ministry of Health. Is that correct?

Dr CRETIKOS: Yes.

The Hon. ANTHONY D'ADAM: Can I ask why the Ministry of Health did not make a submission to this inquiry?

Dr CRETIKOS: I am sorry, I was not party to the process of making submissions. I cannot answer that question.

The Hon. ANTHONY D'ADAM: Okay. Fair enough. Can I also ask about your assessment? You are a public health doctor. What is your assessment of the impact of this legislation will have on the public health efforts in relation to dealing with hepatitis C, hepatitis B and HIV? What do you think the impact of legislation will have on those public health efforts?

Dr CRETIKOS: As I mentioned in the opening statement, I think, the importance of reducing any stigma and discrimination and improving the quality and accuracy of information about bloodborne viruses is paramount to engaging people in treatment. We have had incredible success in New South Wales in engaging people in treatment both for hepatitis C and HIV and have reductions in the level of infection in the community as a result. If people are discouraged from accessing treatment, then in fact the risk may increase both to the people in the community as well as the workers that are looking after them because those treatments are not managed appropriately and are not being treated.

The Hon. ANTHONY D'ADAM: I see.

Dr CRETIKOS: The reduction of hepatitis C in the prison environment is probably one of the most important ways you could reduce the risk to people working in prisons.

The Hon. ANTHONY D'ADAM: So do you think that this will encourage or discourage people from voluntarily seeking testing?

Dr CRETIKOS: There is a compact with health services when you access treatment that it is going to be provided in your interest and for your benefit and we generally would only seek testing when it has been consented to, unless the most exceptional circumstances apply, and in this case there are so many considerations about bloodborne viruses and the level of misinformation that it is likely to reduce people's trust in the health services that are being provided both within and outside of Correctional Services in the community and may reduce access to treatment and access to care.

The Hon. ANTHONY D'ADAM: We heard some evidence from the Public Service Association [PSA] about the prevalence of hepatitis C in the correctional system. Do you have any evidence that you can provide in relation to prevalence of hepatitis C among inmates in the correctional system?

Dr CRETIKOS: Yes. I do not have the exact figures to hand, but it is substantially higher than in the general community. I think I have seen figures recently of around 20 times higher than the general community. However, the prevalence of hepatitis C is much less of a concern in this particular circumstance than the risk of exposure to transmission of infection, and so the circumstances of the injury are paramount in determining whether there is a risk of transmission of infection. And the other consideration is whether there are other means where you could reduce the risk of exposure through the processes that are put in place, both for the people within the correctional services as well as the workers. I have tried to allude to the fact that the access to timely and appropriate expert care is the single most important thing to allaying people's anxieties, which may be unfounded.

Even accessing care through regular channels such as general practitioners or emergency departments may not guarantee you access to the appropriate expert care that you may need and the appropriate advice. We are aware of circumstances where people have been provided incorrect advice or delayed advice because they have not been provided access to the appropriate, timely care which, considering the availability of telephone services and telehealth services, and the availability of a seven-day service for health workers, should not be a barrier.

The Hon. ANTHONY D'ADAM: Are you in a position to provide any evidence around the management of hep C and hep B in the correctional centre, or is that a question that we should direct to Justice Health?

Dr CRETIKOS: I think that is probably better answered by an infectious disease physician.

The Hon. TREVOR KHAN: There might be some evidence that Ms Robson or Mr Smith could give with regard to the provision of services to inmates for instance on admission with regard to—

Mr DAVID SHOEBRIDGE: Screening for hep B and treatment for hep C.

The Hon. TREVOR KHAN: Yes.

Ms ROBSON: I do not specifically have anything to hand around screening on admission into custody. That is very much a matter for Justice Health in terms of what they do and do not do. Mr Smith may be better able to comment on that.

Mr SMITH: We do not delve into it. They do an interview when they come into us that is all around care in custody, and then Justice Health spend probably an hour with them after that going through all that sort of stuff with them.

The Hon. TREVOR KHAN: Mr Smith and Ms Robson, the evidence that has already been given is that you have an obligation essentially as employers to ensure a safe work environment. I understand the nature of public services and the division of responsibilities, but you are bringing into a correctional facility potential infection. Surely you just cannot say, "Well, that is the way it has always been, so we are just going to have it continue in that way," are you?

Ms ROBSON: There are a number of aspects to that. Firstly, we provide our staff with information around minimising the risk of contraction of diseases that might be there, and that includes provision of PPE if they are doing searching, provision of PPE if they are dealing with blood spills and so on.

The Hon. TREVOR KHAN: One of the things that we have learned out of COVID is that the provision of PPE is important but it is a final step. The first thing is to avoid infection using space and all these other things that we have talked about. So you have a facility where you are getting people who are coming in who are likely to have a higher than the overall community risk of carrying bloodborne viruses. What does Corrective Services do to try to minimise the risk of that in the facility? And it is not by the provision of PPE.

Ms ROBSON: I was going to also mention that there have been a number of programs run in jails, both by Corrective Services but also in conjunction with Justice Health, around treatment for hepatitis C that have been quite effective. The SToP-C program, which has probably been mentioned in inquiries such as this previously—I understand that there will be a major report into that released later this year, but the headline is that it has been very successful. There have also been programs that Justice Health has been involved in. It is not just about leaving it to PPE; it is about methods such as prevention of hepatitis C, which provides both the dual benefit of improving health outcomes but also protecting our staff.

The Hon. TREVOR KHAN: My final question to you, Ms Robson, is on notice. Could you provide us with information on the ongoing programs made available to prisoners that assist in the reduction of bloodborne viruses in Corrective Services?

Ms ROBSON: I can certainly find out information that is within the remit of Corrective Services. As I said, and as Mr Smith confirmed, the provision of health services directly to those in custody is by Justice Health, and for various privacy reasons our staff do not ordinarily have access to that information.

Mr DAVID SHOEBRIDGE: But I think the question is about prevalence, not individual patients.

The CHAIR: Mr Shoebridge, I will give you the opportunity after Mr Roberts has had an opportunity to ask his questions.

The Hon. ROD ROBERTS: Dr Cretikos, you referred to the policy directive of NSW Health in relation to HIV, hep B and hep C for the management of healthcare workers. Paragraph 5.2 of that document states:

> 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 …

Why is that the case?

Dr CRETIKOS: That is one of the considerations that would inform the management of people with bloodborne viruses, or who have been exposed to bloodborne viruses, but it is not the only consideration.

The Hon. ROD ROBERTS: But why is it in the document? Is it best practice?

Dr CRETIKOS: Wherever possible we will obtain all information, but our practice is to do that voluntarily.

The Hon. ROD ROBERTS: Certainly. Look, consent is not an issue. The document goes on further to say obtain consent. We are not talking about consent. Why is it recommended that the source patient be tested?

Dr CRETIKOS: So as I said, it provides the additional information that may involve management.

The Hon. ROD ROBERTS: And the management of that potential illness?

Dr CRETIKOS: But I would just like to add that it is unlikely to inform the immediate management, and the immediate management in some cases, based on the level of risk and exposure, would be to take no further action.

The Hon. ROD ROBERTS: Certainly, but it is in there that it is best to do that.

Dr CRETIKOS: Yes. And in some cases if the exposure is very high risk, the action would be to take immediate management regardless of the test result.

The Hon. ROD ROBERTS: Certainly.

Dr CRETIKOS: And then there is a grey zone in between where the management and the duration of treatment may be influenced by the test results of the person who was the third party in this case.

The Hon. ROD ROBERTS: Continuing on in that same department of health document, page 9 of the directive states:

> Advice for the exposed HCW during follow up period
>
> …
>
> - Not to donate plasma, blood, body tissue, breast milk or sperm
> - To protect sexual partners by adopting safe sexual practices (use of condoms)
> - To seek expert medical advice regarding pregnancy and/or breastfeeding
> - To seek medical attention about any acute illness (i.e. fever, rash, myalgia, fatigue, malaise, lymphadenopathy, anorexia).

So forget donating this now. What real-life correlation would that have to a Corrective Services officer or a police officer who was in a marriage? It says not to donate sperm, so are you suggesting that a corrections officer, for example, has to practice safe sex with his wife? Would that be the recommendation?

Dr CRETIKOS: So the first thing is to determine whether there is, in fact, a risk of transmission, because none of those actions may, in fact, be required if there is no risk of transmission.

The Hon. ROD ROBERTS: But it is the recommended procedure in the healthcare document itself.

Dr CRETIKOS: Not if there is no risk of transmission.

The Hon. ROD ROBERTS: That is not my reading of it. It says in the "follow up period", so therefore whilst we are waiting for confirmation you should not donate your breastmilk. So if we have a Corrective Services officer who is female and who is breastfeeding at the time, what is the implication there?

Dr CRETIKOS: Do you mind if I take you to appendix A which gives the flowchart?

The Hon. ROD ROBERTS: Yes, sure.

Dr CRETIKOS: In the event that there is an assessment of the risk of the injury and there is no risk, there is no post-exposure prophylaxis required. The bloodborne virus testing of the source is not required and there is no follow-up required.

The Hon. ROD ROBERTS: What if there is exposure?

Dr CRETIKOS: There may be exposure, but is there a risk of transmission?

The Hon. ROD ROBERTS: Let us say there is. There is a Corrective Services officer who is involved in an incident with a prisoner and there is the potential for blood transferral.

Dr CRETIKOS: In that situation you can see that the flowchart becomes quite complex, and that is why it does actually require an expert medical practitioner to determine the appropriate course of action and to be the one providing the advice about those considerations.

The Hon. ROD ROBERTS: Why are these recommendations in the document then?

Dr CRETIKOS: This is a policy directive about the management that is contingent on this advice being provided by an appropriately experienced practitioner. It would not be expected that anybody would rely on this in order to provide the advice. You would expect that they would have the appropriate training to provide that advice because there are many different situations that cannot all be articulated in a document.

Mr DAVID SHOEBRIDGE: This question is directed to either Mr Follett or Dr Cretikos. In the experience of NSW Health, do you have any data on the number of NSW Health workers who have contracted any of these three bloodborne diseases as a result of the different categories of exposure?

Dr CRETIKOS: In this policy directive that we have been discussing a number of pieces of evidence have been presented. If you could refer to table 5 and table 7. Table 5 presents the Australian and international experience of evidence of HIV transmission following occupational exposure, and in table 7, evidence of hepatitis C transmission following occupational exposure. You can see that for HIV, even in the cases of percutaneous injury—that is a higher risk injury than mucosal surfaces—there have been zero, zero, zero, zero, zero, zero cases in all of those studies.

Mr DAVID SHOEBRIDGE: Even in cases of needlestick injuries and the like, given the appropriate treatment that followed, there are zero cases of HIV—zero conversion.

Dr CRETIKOS: That is correct—over many years across many countries.

Mr DAVID SHOEBRIDGE: Including Australia, Brazil, Denmark, Germany, the Netherlands, Thailand, United Kingdom; that is the global experience.

Dr CRETIKOS: That is correct.

Mr DAVID SHOEBRIDGE: Are you aware of any studies involving prisons, prison populations and Corrective Services officers?

Dr CRETIKOS: I know that there is additional evidence beyond what is presented in this document and perhaps we could provide that on notice should you wish to have that. I just draw your attention to table 7. It describes both percutaneous injuries with source known to be hepatitis C-positive and percutaneous injuries involving large bore catheter needles which are one of the highest-risk types of exposure.

Mr DAVID SHOEBRIDGE: If there is anything further you think would be useful to explain table 7, you have the opportunity to explain it on notice. There is no requirement.

Dr CRETIKOS: No, and there is a further piece of information in this document about the risk of transmission for each of the different bloodborne viruses.

Mr DAVID SHOEBRIDGE: This question is to Corrective Services NSW, and I do not mind who answers it. Surely when you are considering your policies to address a risk in the workplace, the first thing you need to do is understand the extent of that risk. Do you agree?

Ms ROBSON: Yes, you do need to understand what the extent of the risk is, but sometimes the fact that there is a risk is also sufficient. There is simply a risk of our staff contracting bloodborne viruses.

Mr DAVID SHOEBRIDGE: You have got detailed occupational health and safety practices and responses; you have got guidelines and policy documents involving the exposure of Corrective Services officers to HIV, hepatitis B and hepatitis C.

Ms ROBSON: We do. There is a document that I have referred to on several occasions which has been crafted specifically for the custodial environment.

Mr DAVID SHOEBRIDGE: I invite you to table the document.

Ms ROBSON: Certainly. I can take that on notice. I do not have a spare copy with me today.

Mr DAVID SHOEBRIDGE: We have a photocopier.

Ms ROBSON: If you want it with all my scribbles over it, you are welcome to it.

Mr DAVID SHOEBRIDGE: That is fine.

The CHAIR: You are able to take the question on notice and provide it, so if you do not want those personal notes—

Ms ROBSON: I think that would be preferable.

The CHAIR: Yes.

Mr DAVID SHOEBRIDGE: It may be available online. You can send the link by email to the secretariat.

The CHAIR: Mr Shoebridge, the witness has taken the question on notice.

Ms ROBSON: In the usual way.

Mr DAVID SHOEBRIDGE: How is it that you have not done the basic ground truthing and got the data about the number of prison officers who have or have not contracted HIV, hepatitis C or hepatitis B? How have you done this policy development in such a vacuum? Why have you not got that basic ground-truthing done?

Ms ROBSON: As I have indicated, and as our policy documents make clear, staff are not obligated to advise us of their own bloodborne disease status. There are health rules around that and in terms of understanding broader risks of contraction, given the understanding around the high likelihood of people in custody having bloodborne diseases, there is research around and I think that was referred to by Dr Cretikos earlier as well. There is a range of research that is saying that people in jail have a much higher level of hepatitis C.

The Hon. ANTHONY D'ADAM: Mr Follett, can I clarify something? Your office was, I suppose, the entity that coordinated the ultimate proposition that has come before us today. Is that correct?

Mr FOLLETT: Yes. Well, the development of the proposal started in the office for police back before 2018 and my area in the Department of Communities and Justice took it over after the election and the machinery of government changes. We acted as a coordinating agency with Health—who were involved—Corrective Services, and New South Wales police.

The Hon. ANTHONY D'ADAM: So all of the key bureaucratic stakeholders were involved.

Mr FOLLETT: Indeed.

The Hon. ANTHONY D'ADAM: And you coordinated that process.

Mr FOLLETT: That is right.

The Hon. ANTHONY D'ADAM: Presumably there were submissions from various stakeholders about the proposition that was being advanced. Did you receive a submission from NSW Health?

Mr FOLLETT: Health was in the working group.

The Hon. ANTHONY D'ADAM: Can you summarise the view that was articulated by NSW Health through that process?

Mr FOLLETT: I cannot disclose too much. A lot of the conversations were obviously a Cabinet process, so I cannot go into the detail in relation to cabinet-in-confidence discussions. However, I can talk about what the bill tries to do in terms of balancing the risks and the objectives, if you like. The way that the bill is designed to work is essentially almost like an escalating response to deal with risk. I know Mr Shoebridge's questions in relation to getting in front of an expert and Dr Cretikos' evidence in relation to getting in front of an expert quickly is really important to get that fulsome advice. Well, the bill tries to set that out, so a prescribed worker that is impacted needs to get in front of a relevant medical practitioner within 24 hours—

Mr DAVID SHOEBRIDGE: It is just a GP; it is nothing like what Dr Cretikos says.

The CHAIR: Mr Shoebridge, order!

Mr FOLLETT: Well the definition—

Mr DAVID SHOEBRIDGE: It is nothing like that. You are misrepresenting Dr Cretikos' evidence and the bill.

The CHAIR: Order!

Mr FOLLETT: The definition of the "relevant medical practitioner" provides that it should be someone with relevant expertise in bloodborne viruses. There is an alternative pathway for a GP to provide that advice. There are a couple of other facets in relation to that, which is that whoever provides that—so the relevant medical professional who provides that advice—has to consider the risks. One of the issues there is, if it is a GP that does not have the capacity to provide that advice in accordance with the provisions required in the statute, I think there would be an expectation that they would.

The Hon. ANTHONY D'ADAM: Under the drafting, that information is provided to the senior officer who is making the decision. But it is not decisive in the drafting, is it?

Mr FOLLETT: In terms of—determinative in making the decision?

The Hon. ANTHONY D'ADAM: Yes.

Mr FOLLETT: Correct, but—

The Hon. ANTHONY D'ADAM: So they do not have to actually accept the advice. Is that right?

Mr FOLLETT: I think one important thing is—Dr Cretikos might want to comment on this. The information to get to the prescribed worker is the really critical part.

The CHAIR: We are almost at time. I just want to ask one follow-up question of Dr Cretikos and Mr Khan has indicated he has got a question as well. Dr Cretikos, while I accept a lot of the evidence you have provided around statistics and risk profiles, do you accept that, from a mental health standpoint, the fear of contamination of a frontline worker—whether the risk be on the high side of the profile or low side of the profile—would have an effect on their mental health? And that the mechanisms within this bill would have the potential to help alleviate some of that mental health strain on the frontline worker?

Dr CRETIKOS: Our own frontline health workers are in this position every day and we follow the procedure that I have outlined. In terms of the fear and anxiety, we would believe that the best way to allay that fear and anxiety is to provide appropriate advice and not support a misplaced fear where, in many cases, there may be no risk.

The CHAIR: Do you understand that there is some cynicism and scepticism within the ranks of some frontline workers that, when they hear professionals who do not operate in the same environment that they do—

Mr DAVID SHOEBRIDGE: But we are not going down a Trumpian post-truth thing where we just ignore the expert evidence.

The CHAIR: Mr Shoebridge—

Mr DAVID SHOEBRIDGE: Just ignore the expert evidence—put our horns on.

The CHAIR: Mr Shoebridge, I am asking a question and we are doing this yet again.

Mr DAVID SHOEBRIDGE: We are out of time and I object to this line of questioning where you just ignore all the evidence.

The CHAIR: Of course you do.

The Hon. TREVOR KHAN: Mr Shoebridge, just—

Mr DAVID SHOEBRIDGE: We are out of time. This is not helpful.

The CHAIR: This is not your senate preselection, mate.

Mr DAVID SHOEBRIDGE: Nor are you Donald Trump or his mates. We are meant to base it on evidence.

The Hon. TREVOR KHAN: Mr Shoebridge—

Mr DAVID SHOEBRIDGE: Alright, ask the question. Good grief.

The CHAIR: Dr Cretikos, do you accept that those who are in the working environment in Corrections or are frontline workers would have some cynicism around people who are not working in the same environment as them providing advice—"It should be fine, don't worry about it"—when they are getting contrary advice or an understanding that they may have a slight risk, and that it does play on their mental health?

Dr CRETIKOS: I would hope that the strongest assurance you could provide to somebody who has a genuine concern about their own health and wellbeing would be to provide advice from the most expert person, who deals with this issue regularly or on a daily basis, has dealt with similar issues for similar people in similar circumstances for some time, is backed up by the scientific evidence that supports the approach that is being taken, and can provide that in a compassionate and caring way to address the concerns that that person has.

The CHAIR: Thank you very much. I will allow Mr Khan to ask his final follow-up question.

The Hon. TREVOR KHAN: Mr Follett, I am sorry to give you the last one. It relates to clause 8 of the bill and particularly clause 8 (3). Taking into account what I take from your evidence as to where you wish this to go, I am just wondering how you see clause 8 (3). How is it implemented? It seems to me that it is one of those provisions in the bill that actually does not have any effect. How does clause 8 (3) work?

Mr FOLLETT: Well, we hope it has effect. The design of that is to try to get the prescribed worker the information required. In terms of whether there is a carrot or a stick, which might be your question, Mr Khan, in terms of what happens if they do not comply with that provision—

The Hon. TREVOR KHAN: Well, that is a fair way of putting it.

Mr FOLLETT: The idea is that they get the relevant medical information. Consistent with Dr Cretikos' evidence, the prescribed worker needs to get the best information possible. The idea is that the relevant medical practitioner will give them that medical advice.

The Hon. TREVOR KHAN: So you are expecting the GP at Wellington accident and emergency [A&E] to comply with clause 8 (3) of the bill, are you? You know where all these jails are throughout the State. You can pop over the road at Tamworth to the A&E and meet—

Mr FOLLETT: Yes. A couple of things I might add to that—that is a very good point. There are to be health guidelines that are going to sit behind this scheme that are yet to be developed, which hopefully will set out the requirements of a relevant medical practitioner. There are health lines that may be able to deliver this, but it is much better to get the prescribed worker in front of the relevant expert that can advise about the risk. If that is not possible, the guidelines will talk about your obligations. We would hope that a relevant medical practitioner that cannot deliver that can inform the prescribed worker that they cannot comply. The other thing I would say is that when it goes to a senior officer for a decision, one of the parts in terms of making a decision that is justified in all the circumstances is what that conversation or advice entailed, or who they went to see. They can factor that in. Now there is no determinative nature of those provisions in the way that they link up, but the concept is to use the statute as much as possible to get them in front of the relevant medical practitioner.

The Hon. ANTHONY D'ADAM: But there is no requirement for written advice—

The CHAIR: No, no. We are past time. Thank you for attending the hearing today. The Committee has resolved that answers to questions on notice will be returned to us within 14 days. The secretariat will contact you in relation to the questions you have taken on notice.

(The witnesses withdrew.)

(Short adjournment)

PAUL MILLER, Acting NSW Ombudsman, affirmed and examined

The CHAIR: . Thank you very much Mr Miller. Would you like to start by making a short opening statement?

Mr MILLER: I would like to pay respects to Elders past and present of the Gadigal people of the Eora nation, on whose land we are meeting today. I will not repeat in detail what we have said in our submission but will just add some short supplementary comments. I note in hearing some of the proceedings of this Committee that a number of stakeholders, including both those who support and oppose the bill, have indicated that the proposed monitoring and reporting role of the Ombudsman is an important—to use their term—"safeguard" in the bill. We agree that the role of an independent officer of Parliament to monitor and report on the operation of the regime, if it is implemented, is important and appropriate. There are also numerous precedents for where that has occurred in the past. The NSW Ombudsman has had a number of similar roles. I think we counted around 28 previous pieces of legislation where we had similar functions. Like this one, most of those relate to new functions being given to police or Corrective Services, usually of a coercive nature.

However, my concern in the issue that I have raised in my submission is that simply conferring a legislative monitoring function on the Ombudsman is not in itself a substantive safeguard unless we are also given the ability in practice to undertake that function effectively and in accordance with what the Parliament and the community would expect. In practice our ability to perform this function depends on two things. The first is the power to access all the information that we will need. The second is necessary resourcing, that is, the people to do the work. Without those two things we will not be able to be the safeguard that stakeholders seem to recognise is warranted. Indeed, conferring a function without those necessary powers and resources may do more harm than good insofar as it may give Parliament, stakeholders and the community a false confidence of independent oversight.

All that said, the Ombudsman is the servant of Parliament and we will perform whatever function we are conferred within whatever resource, power and other constraints are imposed upon us. However, in our submission we have requested two things. The first is an amendment to the bill to ensure that all the usual Ombudsman powers in respect of information-gathering and oversight apply to this new function as they do to our other, for example, investigatory functions. The second is a commitment, which ultimately will need to be given by government, that the resources needed to perform the function effectively will be made available.

Apart from those two things—and if I might be so bold—there is one more thing that would be particularly useful for me if this Committee and the Parliament could consider that would assist us in performing our oversight role and that is an element of guidance. Firstly, guidance as to any particular issues that this Committee or the Parliament would like or expect us to particularly examine when we do come to monitor and report on the operation of the regime. I note that in the other place there has already been debate around the importance of looking at the extent to which the regime may have a disproportionate impact on, for example, Aboriginal people. Of course, that is something that we will explore in more detail with this function. The second guidance that would be useful to us is any clarity that the Committee and the Parliament can provide as to how it intends or expects the provisions of the bill to be interpreted and applied.

In monitoring and reporting on the Act in 12 months' time, conceptually the questions that we will ask ourselves will be things like: How is the regime operating in practice and is it operating the way that it was intended to operate? Are the objects of the bill being achieved in the way Parliament thought they were being achieved? Are there any unintended or unanticipated consequences or impediments to achieving those policy objectives? Obviously it would assist us if the bill were drafted as clearly as possible to articulate Parliament's intention but, even in the absence of that, when we perform our role we can do more than a court in terms of looking behind what the Parliament genuinely intended with this legislation.

So the more clarity we have in terms of what Parliament intends and expects—or at least a shared understanding of what particular provisions of the bill mean—the easier our job will be in assessing practice against intent. I will not go into detail here in that regard, but I will provide three particular examples where, having listened to some of the proceedings before this Committee, some clarity or certainty around what is intended by the bill would be very useful to us. The first is the obvious one about the meaning of "comes into contact with the person's bodily fluid as a result of the person's deliberate action". I have listened to the debate about what "deliberate action" means in this context and I have to say I am none the wiser as to what that provision is intended to mean.

The Hon. TREVOR KHAN: You are not alone.

Mr MILLER: The second is the criteria for determining a mandatory disease test application. Again, the legislation on its face provides only one criteria, which is that the determining senior officer considers it justified in all the circumstances. The question is: How does Parliament and essentially this Committee intend the senior officer to apply that justification test? When will it be justified? Will it only be justified if it was a deliberate act, for example? The legislation does not specify that, but it would be useful to know if that is the intent of Parliament. The third one—and I am not sure whether this has come up in the proceedings so far—concerns the use of force against detained people and whether there is a temporal element associated with that. The bill is clear that force can be used and only used against the detained person. What is not entirely clear is the intention around the timing under which that person is detained. Is all that matters that the person is detained at the time the testing is to be implemented? In which case, for example: a person who is not detained may be subject to an order and refuses to comply with the order; it is a criminal offence; the person is arrested; is then in detention; and then may force be used against them? It is not clear if that is the intent of that provision. Those are my opening comments.

The Hon. TREVOR KHAN: I suppose this is an invitation as much as anything else. I am also interested in clause 28, which you have referred to in the sense that it is limiting. One of the things that does concern me with regard to clause 28 is that it essentially places a prohibition upon the dissemination of information. But it does not actually deal with what happens with the sample. It seems to me that that is an unintended but nevertheless deficiency in the bill, because otherwise that sample could potentially be used for purposes well and truly beyond the objects of this bill. Would you agree that?

Mr MILLER: I agree with the proposition that the bill is currently silent as to what happens with the sample. I agree that it would certainly assist for the legislation, if passed, to clarify what is intended to happen with the sample. I have to be a little bit careful because understanding that we may have a role in 12 months' time to review this legislation and provide views on it I do want to make sure that I am not pre-empting those views. The idea is that those views are expressed in a concluded way based on evidence that we have been able to gather over the 12 months. But to your proposition there is an obvious gap in the legislation insofar as it does not specify what is intended to happen with those samples.

The Hon. TREVOR KHAN: I will go back to another area and that is the detained person issue and you spoke already of the temporal issue. When Deputy Commissioner Lanyon gave evidence this was a matter of some short questioning. While he dealt with the period in custody as giving rise to that, it raises the interesting question also with regard to prisoners. It seems to me that one of the issues becomes, if there is an incident and essentially an application lodged and an order is made, whereas if the person were not detained they have got up to 48 hours to essentially nod their head to the test, but for the detained person in custody the person could essentially be immediately extracted from the cell and essentially subject to a forced removal of blood at that stage. That seems to be the case, does it not?

Mr MILLER: That is how I have read the legislation, yes.

The Hon. TREVOR KHAN: One would think that is potentially problematic in terms of prisoner controls but we will leave that to one side. But is there any logical reason that you can identify as to why a non-detained person has time to give it some thought, but if you are in custody, however extricable or not you are as a human being, you are not actually entitled to any sort of thinking time before the extraction of a sample?

Mr MILLER: It is not immediately obvious to me what the logic of that difference would be. When we come to review the legislation and look at the practice, it may be that a logic emerges, but it is not immediately apparent to me, no.

The CHAIR: Ms Cusack has indicated she wants to ask questions.

The Hon. CATHERINE CUSACK: Thank you. Just in relation to the additional resources that you say would be required, have you actually got details of what the extra resources will be?

Mr MILLER: We have started a dialogue with Treasury as part of the upcoming 2021-22 budget process. It is obviously very difficult to assess exactly the resources that will be needed because one of the things that, again, I think has been commented on in this Committee is the relative paucity of data about, for example, how many incidents and therefore how many likely applications there will be. A significant part of our oversight role will be to monitor those applications and their determination. If there are 10 in the12 months, then presumably our task is much smaller than if there are a thousand. Having said that, there will be some - irrespective of the size of that task - functions that we will need to perform irrespective. What we have said to Treasury, based on our previous experience performing similar roles, is that we are looking at a minimum of four people to undertake the role but then whether it is more than four or not will depend on, as I said, the practice but also the parameters of the final bill.

The Hon. CATHERINE CUSACK: It sounds as though you have actually put in a budget submission for this?

Mr MILLER: Yes.

The Hon. CATHERINE CUSACK: What were the resources that you requested?

Mr MILLER: Essentially it is four people—four people plus some capital funding to support the collection of relevant data and analysis of data.

The Hon. CATHERINE CUSACK: What is the bottom line?

Mr MILLER: It is between a half and a million dollars. I do not know the exact figure.

The Hon. CATHERINE CUSACK: Can you, perhaps on notice, obtain that information for us and just the details of how you arrived at that?

Mr MILLER: Yes. Sure.

The CHAIR: Mr D'Adam has some questions and I will go back to you, Mr Khan, after that.

The Hon. TREVOR KHAN: That is fair—plenty of time.

The Hon. ANTHONY D'ADAM: Mr Miller, I want to ask you about the process of obtaining information for the purposes of discharging the Ombudsman's obligations under the Act. I wonder if you might turn your mind to the process of how the decision of the senior officer is documented and perhaps provide some submission in relation to that. It strikes me from a reading of clause 10 of the proposed bill that there is no obligation that the decision, other than the order, is documented. The grounds and reasons are documented. I think it is open to suggest that that justification might not necessarily be documented.

Mr MILLER: If I can draw your attention to clause 12 subclause (3), which requires senior officers at the end of each quarter to report to the Ombudsman about the determinations in that quarter, including reasons for the determination, our expectation would be that that would be written reasons that outline why the senior officer considered it justified in all the circumstances—what they considered and what criteria they applied.

The Hon. ANTHONY D'ADAM: They are written reasons. So your reading is that they are written reasons that had been produced contemporaneous to the decision.

Mr MILLER: Yes. That would be our expectation.

The CHAIR: Mr Khan, do you have follow-up questions?

The Hon. TREVOR KHAN: My question is not a follow-up to that, but I want to take you to clause 8 (3) of the bill. It seems to me there is an interesting variety of emphasis as to what the impact of this bill will be and how, but it seems that one emphasis, which I think I can assume is led by Health, is that an important underpinning of the bill is that better information will be provided to front-line officers who are the subject of a deliberate act resulting in some form of passing of bodily fluid, but they are given better information as to what the risks are. Have you given consideration as to the monitoring of the provision of that further information?

Mr MILLER: Not detailed at this stage. So if this bill is passed, our first task will be to develop the methodology by which we will undertake our tasks. So that would be involved as the first part of that. The second task typically will be to engage with the agencies usually to form some sort of memorandum of understanding [MOU] about information-sharing. In relation to clause 8 in particular, the requirement on the medical practitioner to provide the prescribed information, if that information is then included with the application, which the bill provides that it should be if it is in writing, then whether or not the medical practitioner—whether medical practitioners are providing that information and providing it in the detail that you would expect should be apparent to both the senior officer but also to us because we should be able to obtain access to the documents surrounding the application and its determination. So, I guess to answer your question, I do not think as a practical matter we would need to engage directly with individual medical practitioners necessarily in order to ascertain whether clause 8 is being implemented in the way that was intended.

The Hon. TREVOR KHAN: All right. Just on an entirely different subject, some of the evidence we received on the first day related to a youth in a Juvenile Justice facility who was a repeated spitter, I think. Did you hear that evidence?

Mr MILLER: I did.

The Hon. TREVOR KHAN: In your information-gathering exercise, are you intending to look not only at the number of individual events but linking that up as to whether we are going to be seeing the same, particularly a prisoner, subject to repeated orders?

Mr MILLER: Yes. That is something that we will definitely be looking at.

The CHAIR: Mr Miller, could I ask this: One of the things we have heard from witnesses yesterday and today has been around the mental health of front-line workers when they have been exposed and are awaiting the clearance that they do not have a bloodborne disease and that this testing regime may provide them some respite for their mental health. How is it that you might go about measuring their success or not of that, given that there is perhaps not as much data on this historically, the success of what is hoped will be one of the outcomes of this bill, should it pass?

Mr MILLER: It is a good question. I will answer it in a number of parts: firstly, to say that with the bill as currently drafted, I think we would not be able to explore that issue because our information-gathering powers would not extend to information about those sorts of things. We can only gather information from the senior officer about the particular application. So it would not authorise us to gather that broader information, which I agree is important. If one of the key objects of the legislation is to protect and promote the physical and psychological wellbeing of officers, some assessment as to whether it is achieving that objective is important. I also agree with the point you made that one of the challenges we will face is a lack of baseline data. In an ideal world you would have that data or you would, in a sense, wait to implement a program like this until you had the data to create the baseline. We do not have that. We are in the real world and we do not always have baseline data.

The third point I would make is that while a monitoring and reporting function does require us to consider the extent to which, in practice, the regime is meeting the objectives of Parliament and the legislation, it will not be and cannot be a formal evaluation in the sense that, for example, the NSW Bureau of Crime Statistics and Research [BOCSAR] would perform, both because that is not our expertise and also because it would not be possible. It would not be possible after 12 months and it certainly would not be possible without the data you referred to.

So what can we look to? We can look to what data the agencies do have. I think there was evidence this morning that there is information in broad terms about the levels of psychologically related, for example, workers compensation or stress leave et cetera. Tying that back to particular incidents in terms of whether they are related to the exposure to bloodborne diseases will be very difficult, but you can look at patterns over time of that. We can take a case study approach. In some of our previous review roles, we have identified particular occasions where, in this case, an order is granted and we have done fieldwork: essentially, spoken to the officer involved and asked them what was their experience—those sorts of things. But I think, because of the absence of quantitative baseline data, necessarily our analysis is likely to be more qualitative of that nature.

The CHAIR: That is part of the concern that I have with measurement around a bill such as this, where the metrics which you will use to measure it—as you outlined, from the senior officer, that data and the like—is all very binary. It is "yes" or "no"; you can put it into a graph and measure it. But the success or not of the intent of what this bill does is harder, sometimes, to measure. I was curious as to your approach to how that would work. Where the binary information that you are collecting may point to a success one way or the other, sometimes the quantitative success with how people are faring with their mental health et cetera is harder to measure. Do you think that is something that is important to factor in when you are developing the reports around this?

Mr MILLER: Yes, absolutely it is. To your point, if you look at the reports that we have written on previous statutory reviews, a lot of them will go into some detail about the limitations of what we are able to do. It may well be—and I suspect it probably will be the case—that we will not be able to express a definitive view as to whether, yes or no, this regime has alleviated the psychological distress that we are told that frontline workers face; and, if it is yes, by how much. We just will not be able to do that. What we might be able to do is provide some kind of indication. For example, the legislation sets out a stepped regime: The worker gets advice, they make an application, there is a determination, and there is an implementation of the order. If what we observe is that following the obtaining of the medical advice as set out in this bill many of the workers decide, "I don't want to proceed with the application anymore," then that might tell us something about their state of satisfaction with the advice that they have been given. It does not tell us anything, obviously, about their subjective psychological state, but it might be important information nevertheless.

The Hon. CATHERINE CUSACK: When you say that the data does not exist, are you saying that you do not have the data or that you know that there is no data?

Mr MILLER: I do not have the data. The question about whether it exists is a question that we will obviously need to ask of the agencies. I think what has been provided to date to this Committee suggests that the

sort of comprehensive data that the Committee has certainly indicated would be useful to it has not been available to date. Whether it will be provided on notice, we will see.

The Hon. CATHERINE CUSACK: Have you not had any meetings yet with the agencies?

Mr MILLER: No, and we would not ordinarily. Just prior to the bill proceeding to Cabinet, we were provided with a draft of the bill and the opportunity to provide comments on it. Being a Cabinet process, it would not be appropriate for me to discuss in detail. But what I can say is that the advice that we have given to this Committee in our submission will not come as a surprise to the Government, and we would not give different advice to the Government than we would give to Parliament, anyway. That has been the extent of our engagement with government to date.

The Hon. CATHERINE CUSACK: This has confused me a bit. We are getting advice that this policy discussion has been going on for about four years. When did the Ombudsman's office become aware of the discussion? Was it just before it went to Cabinet? Were you unaware?

Mr MILLER: I have been with the Ombudsman's office for almost two years. Prior to that I worked in the Department of Justice, so I was certainly aware that there was advocacy from stakeholders for a mandatory disease testing regime. There had been—I think in 2017—a parliamentary committee report that had recommended that the question be explored, so the issue was known in the background. In terms of government formally approaching the Ombudsman to say, "We're considering this and we're considering you having a role," I can find the exact dates, but it was recent: the last six months.

The Hon. CATHERINE CUSACK: I just do not understand how you framed a budget submission without discussing with the agencies what data they have. How can you possibly put together a proposal without the agencies providing some information or you gleaning some feedback about what goes on at the moment so that you can make an informed assessment of what your needs will be?

Mr MILLER: Yes, I take your point entirely. When I say we made a budget submission, it probably puts it too highly. We have bookmarked with Treasury that we will need extra funding and we have provided a very high-level, very indicative indication of the minimum resources we think we will need. There is an intersection here with some work of other parliamentary committees relating to the way in which oversight bodies like us are funded.

One of the recommendations of that other committee is that an office like us have a contingency fund of a certain proportion of our annual budget. If such a fund were created, then this would be the ideal candidate for the application of that fund because you would do exactly as you have suggested. You would wait until the bill has passed so you know the exact parameters of the legislation, you would allow us to work with agencies to find out what information they have got and what we can get, you would allow us to develop our methodology, and then we would have a very clear idea about what is it going to cost to do this work and then we could have recourse to the contingency fund. The problem we have got is that in the absence of that, and given comments about the inappropriateness of our seeking funding out of session, if you like, mid-year funding from the Department of Premier and Cabinet, our only opportunity is in an annual budget process. That is happening now, and that is why we have put in this indicative submission now. Otherwise we would not have done that, for the reasons that you have outlined.

The Hon. CATHERINE CUSACK: On a slightly different topic, the idea of this bill, as I understand it, is to put the needs of the officer who has been subject to assault, to prioritise his or her needs. The oversight process is designed to ensure that it is all done properly. We are dealing, I assume, with a very difficult group of people who are not cooperative, which is why the whole measure is being proposed in the first place. I do not think we are talking about ordinary citizens here at all. We are probably talking about a small group of very difficult people who our frontline services are interacting with. It is important that the oversight process be beneficial to the outcome that we are trying to achieve with the bill, and not another source of complaint and harassment of the officers who we are trying to protect.

Mr MILLER: Agree with that entirely, and also agree that it is for Parliament to determine the policy objectives of the legislation. That philosophical, for lack of a better word, debate about the rights of the worker versus the rights of the third party, and the question about in what circumstances does a third party in a sense forfeit their rights in favour of the others, that is not something that we are going to explore in our review, because in a sense we take the—

The Hon. CATHERINE CUSACK: Decision.

Mr MILLER: —policy objectives as they are given. To break that down, it is very unlikely—and I have to say we have not done the work in terms of our methodology and what we would be looking to report—that we

would even be talking about in terms of rights or balancing rights or anything like that. What we would be talking about is what are the objectives of the legislation. The objectives are clear because they are stated in the bill, which is improving the physical and psychological wellbeing of frontline workers. On the physical side you have got two aspects of that. One is: Does this regime prevent in any way them becoming infected with bloodborne diseases? I do not think there is any evidence that that is what this bill is about.

The Hon. CATHERINE CUSACK: No.

Mr MILLER: The next is treatment: Will it affect the treatment? There has been contested evidence about that. That is something we could look at in 12 months' time and say where an order was made and the results came back, did those results in fact have any impact on the treatment that the frontline officer received or not. Then on the psychological side we have already discussed the difficulty of assessing whether that object is achieved, but we will do our best. Then on the flip side you look at the costs or unintended benefits, or the concerns that have been raised about the bill. For example, there is a concern about whether the regime will result in the perpetuation of misinformation. So, we would look at things like what is the information the frontline workers are getting, what are the policies, are they getting the best most up-to-date medical information. We would look at the costs of the regime. There has been a concern raised about this may be a costly regime to implement, is it diverting costs away from other public health measures. We can look at the cost. We can look at the issue that has been raised by some of the stakeholders about the risks associated with taking blood under conditions of use of force. Are there any incidents where—

The Hon. CATHERINE CUSACK: I ask you to pause there. It is interesting what you envisage reporting on but my question was more specific. When one of these alleged offenders appeals to your office, asks your office to intervene in relation to their case, given that we are trying to serve the wellbeing of the affected officer, my anxiety is that the review process of that case does not actually make things worse for the officer because there is this sense of vexatious complaints against these frontline staff just trying to do their jobs. I think the body cameras were introduced and that has resulted in a bit of a decline in that, which has been positive. But these people are experiencing stress and the motivation behind it is their wellbeing. I am seeking your assurance that the oversight process is not going to be counterproductive to the actual goal we are trying to achieve for these serving officers and frontline staff.

Mr MILLER: Yes, I can give you that assurance.

The Hon. CATHERINE CUSACK: Thank you.

Mr MILLER: I should also say that this legislation does not give us—

The Hon. TREVOR KHAN: A complaint handling.

Mr MILLER: —a new complaint handling role. We do not have a complaint handling role in respect of police generally, but we do have a complaint handling role in respect of many of the other agencies that are covered by the legislation, including Corrective Services.

The Hon. CATHERINE CUSACK: Particularly health, yes.

Mr MILLER: Even apart from this legislation, a person who was subject to a mandatory disease testing order in respect of a Corrective Services officer who believed, and had reason to believe, that there was wrong conduct—and we are talking about unlawful, unreasonable conduct, not just "I didn't like it"—then they could complain to us now outside of this legislation. In terms of our function under this legislation, it is certainly not our intention to be cross-examining workers who put in applications or in any other way exacerbating the difficulties that they may be facing.

The CHAIR: Unfortunately we are almost out of time. I do not see any other burning questions from Committee members, unless Mr Khan?

The Hon. TREVOR KHAN: I just have—no, I will leave it alone.

The CHAIR: I thank you very much for appearing today. The Committee has resolved that answers to questions on notice will be returned to us within 14 days. The secretariat will contact you in relation to the questions that you have taken on notice. That concludes our hearing for today and I thank everyone for participating.

(The witness withdrew.)

The Committee adjourned at 12:29.