Parliamentary Committees

Health Legislation Amendment Bill 2014

Report No. 59
Health and Community Services Committee
November 2014

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Abbreviations and glossary

Note: terms below in italics are defined terms in legislation

AHPRA	Australian Health Practitioner Regulation Agency
Ambulance Service Act	*Ambulance Service Act 1991*
the Bill	Health Legislation Amendment Bill 2014
chief executive	Director-General of the Department of Health
chief executive officer	Chief executive officer of a local government
the committee	Health and Community Services Committee
the department	Department of Health
HHB Act	*Hospital and Health Boards Act 2011*
HHS	Hospital and Health Service
LGAQ	Local Government Association of Queensland
Mental Health Act	*Mental Health Act 2000*
the Minister	Hon. Lawrence Springborg MP, Minister for Health
PH Act	*Public Health Act 2005*
RCA	root cause analysis
RCA Report	*Review of Root Cause Analysis Legislation* Report
RIHE Act	*Research Involving Human Embryos and Prohibition of Human Cloning for Reproduction Act 2003*
RS Act	*Radiation Safety Act 1999*
TGA	Therapeutic Goods Administration
Tobacco Act	*Tobacco and Other Smoking Products Act 1998*
Transplantation and Anatomy Act	*Transplantation and Anatomy Act 1979*

Chair's foreword

On behalf of the Health and Community Services Committee of the 54th Parliament of Queensland, I present this report on the Health Legislation Amendment Bill 2014 (the Bill).

The Bill was introduced into the Legislative Assembly by the Minister for Health on 9 September 2014. The committee was required to report to the Legislative Assembly by 17 November 2014.

The Bill amends eight health portfolio Acts to support policy initiatives of the Government and to improve the effective operation of those Acts.

The most significant amendments, and those that attracted the most comments in submissions, are the amendments to the *Tobacco and Other Smoking Products Act 1998* to extend smoking bans to hospitals, schools and prisons, and to apply existing cigarette and tobacco legislation to personal vaporising devices (for example, e-cigarettes) and the *Public Health Act 2005* amendments, which transfer civil liability for asbestos-related events from local government to the State.

The committee also received submissions raising concerns about the regulation of advertising of the buying of human tissue under the *Transplantation and Anatomy Act 1979*.

In considering the Bill, the committee's task was to consider the policy to be given effect by the Bill, and whether the Bill has sufficient regard to the rights and liberties of individuals and to the institution of Parliament.

On behalf of the committee, I thank those who made written submissions on this Bill. Thanks also to officials from the Department of Health who briefed the committee, the witnesses who provided evidence at the public hearing, the committee's staff, and the Technical Scrutiny Secretariat.

I commend the report to the House.

Trevor Ruthenberg MP
Chair

Recommendations

Recommendation 1 2

The committee recommends that the Health Legislation Amendment Bill 2014 be passed.

Recommendation 2 22

The committee recommends that the Minister for Health ensure that the Department of Health work with Hospital and Health Services and private health facilities to ensure that appropriate nicotine replacement therapy products are made available to patients during their stay in a health facility.

Recommendation 3 24

The committee recommends that the Minister for Health ask the Department of Health to:

- review local government's current use of the power at sections 26ZPA to 26ZPE of the *Tobacco and Other Smoking Products Act 1998* to ban smoking at public transport waiting points and outdoor pedestrian malls
- if current regulation by local government is deemed inadequate to protect the public from harm, consider introducing a state-wide smoking ban at public transport waiting points and outdoor pedestrian malls
- consider extending existing and proposed smoking bans to outdoor areas frequented by the public, including, for example, TAFE colleges.

Recommendation 4 28

The committee recommends that the Bill be amended to ensure that the definitions of *personal vaporiser* and *personal vaporiser related product* capture all of the vaporiser devices and products which are intended to be regulated.

Recommendation 5 33

The committee recommends that, if evidence becomes available on the potential harm caused by the use of nicotine and non-nicotine vaporisers, the Minister for Health initiate a review the regulation of vaporisers, as proposed in the Bill.

Recommendation 6 33

The committee recommends that the Minister for Health work with his colleagues in the Health Council of the Council of Australian Governments to urgently introduce statutory product standards for all personal vaporiser devices and a requirement for all vaporisers and packaging to contain health warnings and instructions on the safe use of the device.

Recommendation 7 36

The committee recommends that the Minister for Health:

- examine the options for amendment of section 41 of the *Transplantation and Anatomy Act 1979* to remove the requirement for approval of advertisements for altruistic non-commercial advertising for sperm or eggs for fertility treatment
- with a view to achieving a nationally consistent approach to advertising, raise the issue with health ministers in other jurisdictions through the Health Council of the Council of Australian Governments.

Recommendation 8 **39**

The committee recommends that the Bill be amended to remove the potential ambiguity in drafting of proposed new section 454D, inserted by clause 43, so there is no doubt about the circumstances in which the State may recover a financial contribution from a local government for a liability indemnified under proposed new section 454C.

1 Introduction and overview of the Bill

1.1 Role of the committee

The Health and Community Services Committee (the committee) was established by resolution of the Legislative Assembly on 18 May 2012, and consists of government and non-government members.

Section 93 of the *Parliament of Queensland Act 2001* provides that a portfolio committee is responsible for considering:

- the policy to be given effect by the Bill
- the application of the fundamental legislative principles to the Bill.

1.2 Committee process

The Health Legislation Amendment Bill 2014 (the Bill) was introduced into the Legislative Assembly on 9 September 2014 by the Hon Lawrence Springborg MP, Minister for Health (the Minister). The Bill was referred to the committee for examination. The committee was required to report to the Legislative Assembly by 17 November 2014.

Officers from the Department of Health (the department) briefed the committee on the Bill on Wednesday 10 September 2014 (see Appendix B).

The committee invited submissions on its website and by notice to subscribers to updates on the work of the committee. It also directly invited submissions from 119 stakeholder organisations. Twenty-seven submissions were received (see Appendix A).

The committee held a public hearing on the Bill on 29 October 2014 to hear from invited witnesses (see Appendix C)

Transcripts of the briefing provided by the department on 10 September 2014, the public hearing on 29 October 2014 and the submissions received and accepted by the committee are published on the committee's webpage at www.parliament.qld.gov.au/hcsc.

On 24 October 2014, the committee wrote to the department to request a response to certain issues raised in submissions on the Bill. The committee received a response on 3 November 2014.

The committee also wrote to the department on 31 October 2014 to seek further information about issues raised during the public hearing on the Bill. On 31 October 2014, the committee also wrote to the Minister to seek clarification about potential fundamental legislative principles issues (see Chapter 11 of this report).

1.3 Policy objectives and summary of amendments

The Explanatory Notes state the Bill amends eight health portfolio Acts to "support policy initiatives of the Government, and to improve the effective operation of the Acts".[1]

The Bill amends the:

- *Ambulance Service Act 1991* and the *Hospital and Health Boards Act 2011* to make recommended amendments to the legislative framework for Root Cause Analysis (RCA) arising out of the *Review of Root Cause Analysis Legislation*
- *Health* Ombudsman *Act 2013* to clarify that the Privacy Commissioner is appointed under the *Information Privacy Act 2009*, and not the *Right to Information Act 2009*

1 Explanatory Notes, Health Legislation Amendment Bill 2014, p.1, available at https://www.legislation.qld.gov.au/Bills/54PDF/2014/HealthLAB14E.pdf

- *Hospital* and *Health Boards Act 2011* to include a new exception to the duty of confidentiality to allow the sharing of patient information with non-government service providers who provide public health services for Queensland Health
- *Mental Health Act 2000* to amend the definition of *psychiatrist*, following changes made to the categories of registration by the Australian Health Practitioner Regulation Agency (AHPRA)
- *Public Health Act 2005* to transfer civil liability for asbestos-related matters from local governments to the State
- *Radiation Safety Act 1999* to allow the renewal of recently expired renewable Act instruments, clarify the operation of the Act in relation to banned radiation sources and practices, and clarify the responsibilities for records of the former Radiological Advisory Council of Queensland
- *Tobacco and Other Smoking Products Act 1998* to extend smoking bans to health facilities, school grounds and in prisons and apply existing tobacco laws to personal vaporising devices
- *Transplantation and Anatomy Act 1979* to facilitate national blood supply arrangements and legitimate trade in tissue-based therapeutic products, allow the Minister to delegate functions under the Act and clarify that the *Research Involving Human Embryos and Prohibition of Human Cloning for Reproduction Act 2003* prevails to the extent of any inconsistency with the *Transplantation and Anatomy Act 1979*.[2]

1.4 Should the Bill be passed?

Standing Order 132(1) requires the committee to recommend whether the Bill should be passed. The committee considered the Bill, information provided by the department and the information and views expressed in the 27 submissions received and accepted.

After considering the policy issues discussed in the following chapters of this report, and considering whether the Bill has sufficient regard to the fundamental legislative principles, the committee decided to recommend that the Bill be passed.

Recommendation 1

The committee recommends that the Health Legislation Amendment Bill 2014 be passed.

2 Explanatory Notes, p.1

2 Amendments to the *Ambulance Service Act 1991* and the *Hospital and Health Boards Act 2011* – Root Cause Analysis

2.1 Introduction

2.1.1 Current legislation

The Explanatory Notes describe root cause analysis (RCA) as:

> *… an internationally recognised approach to the analysis of serious clinical incidents associated with the provision of healthcare, such as those resulting in unexpected death or serious injury. It involves the use of a multidisciplinary team to retrospectively analyse the sequence of events leading to a clinical incident, identify any contributory factors, and make recommendations about how similar events may be prevented from occurring in the future.*[3]

The *Ambulance Service Act 1991* (Ambulance Service Act) and the *Hospital and Health Boards Act 2011* (HHB Act) make provision for the conduct of RCAs by public and private health service entities in Queensland.[4] Both Acts provide for the use of RCA "as a quality improvement technique to assess and respond to reportable events".[5]

The term *reportable event* includes death, permanent injury, loss of function of a person and suspected suicide of person receiving inpatient health care. A number of causal factors for a *reportable event* are defined, including incorrect medication management, intravascular gas embolism, unreasonable delay in providing the ambulance service, failing to meet recognised standards for providing the ambulance service and performing the wrong procedures on the person, or performing of a procedure on the wrong part of a person's body.[6]

2.1.2 Review of Root Cause Analysis Legislation

In March 2010, the department, assisted by the Queensland Ambulance Service, commenced a review of RCA provisions to "… ensure they continue to adequately meet community expectations and that the provisions remain appropriate".[7]

The Minister tabled the *Review of Root Cause Analysis Legislation Report* (RCA Report) in Parliament on 22 November 2013. The RCA Report recommended five areas for legislative amendment:

> *1. Maintain the current enabling legislation approach to RCA.*
>
> *2. Treat the Chain of Events documentation as part of the RCA Report and subject to the same disclosure and release provisions. The Chain of Events documentation should remain inadmissible in legal and disciplinary proceedings.*
>
> *3. Include a decision of an RCA team member to report 'public risk notifiable conduct' to the Australian Health Practitioner Regulation Agency (AHPRA) as an explicit ground for stopping an RCA.*
>
> *4. Require RCA teams to notify the Commissioning Authority of the grounds for stopping an RCA and the information that forms the basis for that ground.*
>
> *5. Expand the scope of the legislation to include non-government organisations prescribed under regulation.*[8]

3 Explanatory Notes, p.2
4 Explanatory Notes, p.2
5 *Ambulance Service Act 1991*, s.36C; and *Hospital and Health Boards Act 2011,* s.93
6 *Ambulance Service Act 1991*, s.36A; and Hospital and Health Boards Regulation 2012, s.29
7 Explanatory Notes, p.2

2.2 Proposed amendments

The Bill implements the RCA report recommendations by amending the Ambulance Service Act and the HHB Act to:

- remove references to a *chain of events document*[9] to provide that *chain of events documents* are to form part of a RCA report and are, therefore, subject to the disclosure and release provisions which apply to a RCA report[10]
- expand the scope of RCA to include a *prescribed health service facility* (which may include a non-governmental organisation prescribed by regulation)[11]
- provide protection from liability for RCA team members and *relevant persons*[12] commissioned to conduct a RCA for a reportable event at a *prescribed health service facility*[13]
- provide that an RCA team may stop a RCA, if a team member, who is a registered health practitioner, reasonably believes the event involves the behaviour of a registered health practitioner that constitutes public risk notifiable conduct and notifies the Health Ombudsman[14]
- provide that where an RCA team stops a RCA and notifies the commissioning authority, the notice must state why a RCA was stopped to allow the authority to make a more informed decision about what further investigations or actions are required[15]
- provide that a commissioning authority must not disclose information contained in a notice stating why a RCA was stopped or give someone else a copy of the notice, except when required to do so by the coroner or police, or where it is necessary or incidental to a person taking disciplinary or other action in relation to the *reportable event*[16]
- provide that where a commissioning authority receives information, other than in a notice stating why the RCA stopped, that leads the authority to reasonably believe that the event involves a blameworthy act, or that the capacity of the person involved in delivering the ambulance service was impaired by alcohol or a drug, the authority must direct the RCA team to stop the RCA[17]
- replace references to the disclosure of information to the *National Agency* (AHPRA) with references to disclosure to the *Health Ombudsman*, as the Health Ombudsman now receives and considers notifications about health practitioners in Queensland.[18]

2.3 Submissions

Only two submissions commented on the proposed RCA amendments. Children's Health Queensland Hospital and Health Service (HHS), and the Queensland Ambulance Service (QAS) both support the proposed amendments. The HHS considered the amendments would "… clarify the intent and improve the workability of the legislation",[19] and the QAS stated that the amendments would

8 Department of Health, *Review of Root Cause Analysis Legislation*, 2013, p.1, http://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2013/5413T4151.pdf

9 *Ambulance Service Act 1991*, s.36G(2) and *Hospital and Health Boards Act 2011*, s.100 (2) define a *chain of events document* as a document that details, or pictorially represents, the chain of events identified by the RCA team as having led to the happening of a reportable event.

10 Health Legislation Amendment Bill 2014, cls.4, 5, 10, 11, 12, 14, 15, 22, 24, 25, 28, 29, 30, 33, 38 and 39

11 Health Legislation Amendment Bill 2014, cls.22 and 23

12 A *relevant person* for a RCA team is defined as a person authorised by the RCA team to help the RCA team in the performance of its functions, including administrative services, providing advice and preparing reports (*Hospital and Health Boards Act 2011*, schedule 2).

13 Health Legislation Amendment Bill 2014, cl.32

14 Health Legislation Amendment Bill 2014, cls.7 and 26

15 Health Legislation Amendment Bill 2014, cls.7 and 26

16 Health Legislation Amendment Bill 2014, cls.11, 13 and 29 and 31

17 Health Legislation Amendment Bill 2014, cls.8 and 27

18 Health Legislation Amendment Bill 2014, cls.9, 15, 21 and 28

19 Children's Health Queensland HHS, Submission 27, p.1

"… help to ensure that root cause analysis remains a valuable tool for improving patient safety in Queensland".[20]

2.4 Committee comment

The committee considers that the amendments are appropriate and notes that they were developed after detailed consideration through the RCA Report which was tabled in the Parliament in late 2013.

20 Queensland Ambulance Service, Submission 21, p.1

3 Amendments to the *Hospital and Health Boards Act 2011* – external service provider access to confidential patient information

3.1 Introduction

Section 142 of the *Hospital and Health Boards Act 2011* (the HHB Act) creates a duty of confidentiality. It provides that a *designated person* (for example, a health service employee, chief health officer or health professional) must not disclose confidential patient-identifying information to another person unless the disclosure is required or permitted under the HHB Act.

Section 143 provides for an exemption to the duty of confidentiality where disclosure of confidential information by a designated person is required by an Act or law. The disclosure of confidential information, contrary to section 142, is an offence which attracts a maximum penalty of 100 penalty units ($11,000).

The committee is aware that some HHSs contract external service providers to deliver services, often at Queensland Health facilities, under service level agreements. The Explanatory Notes give the example of Cape York, where chronic disease care and maternal and child health services are delivered by the HHS in partnership with the Royal Flying Doctor Service and Apunipima Cape York Health Council.[21]

The Explanatory Notes state that under such arrangements, "staff of external service providers need access to Queensland Health information systems in order for clinicians and administrative staff to read, review and add information to patient medical records, to ensure continuity of care".[22]

Under the HHB Act, however, Queensland Health staff may breach the duty of confidentiality by allowing external service providers access to Queensland Health information systems.

3.2 Proposed amendments

Clause 36 inserts new sections 161A and 161B into the HHB Act to provide for a new exemption to the duty of confidentiality to allow access to external service providers.

New section 161A provides that the chief executive of Queensland Health may authorise an external service provider, or a person engaged by an external service provider, to access a Queensland Health information system – either paper-based, electronic or both. New section 161B provides the authority for an external service provider, or a person engaged by that provider, to access Queensland Health information systems in accordance with an authorisation under section 161A.

The Explanatory Notes state that:

> *This new exception will ensure that Queensland Health staff do not breach the duty of confidentiality in circumstances where staff of organisations access Queensland Health information systems while providing health services for the Queensland Health system under funding, service or partnership arrangements.*[23]

3.3 Submissions

The Children's Health Queensland HHS, The Royal Australian and New Zealand College of Radiologists, the Torres and Cape HHS, and Occupational Therapy Australia – Queensland Division support the amendments.

21 Explanatory Notes, p.3
22 Explanatory Notes, p.3
23 Explanatory Notes, p.13

They consider that the amendments will assist in the seamless delivery of patient care,[24] help reduce unnecessary delays and avoid potential clinical incidents relating to follow-up,[25] and provide health practitioners with access to the information they need to do their jobs in the best interest of patients.[26]

The Townsville HHS called for provisions to enable a HHS chief executive to authorise an external service provider to access Queensland Health information systems.[27] The committee notes that section 46 of the HHB Act provides that the chief executive of Queensland Health may delegate to a HHS chief executive the power to authorise an external service provider to access Queensland Health information systems. Clause 20 amends section 46 of the HHB Act to prevent a HHS chief executive sub-delegating the power to authorise access.

3.4 Committee comment

The committee considered whether sufficient safeguards are proposed to protect the privacy of individuals who receive treatment from a public health service.

The committee notes that the Bill includes the following safeguards:

- the chief executive of Queensland Health, or a HHS chief executive, must authorise access to an information system by an external service provider, or a person engaged by the external service provider[28]
- the chief executive of Queensland Health, or a HHS chief executive, must be satisfied that the disclosure of patient information is necessary for the external service provider to provide a health service in order to make an authorisation[29]
- the authorisation must be in writing, must describe the information system to which the authorisation relates, and may be given on conditions stated in the authorisation[30]
- the external service provider is bound by the National Privacy Principles under the *Information Privacy Act 2009*.[31]

The committee is satisfied with the safeguards proposed in the Bill.

24 Royal Australian and New Zealand College of Radiologists, Submission 24, p.1
25 Torres and Cape HHS, Submission 10, p.1; Children's Health Queensland HHS, Submission 27, p.1
26 Occupational Therapy Australia – Queensland Division, Submission 25, p.2
27 Townsville HHS, Submission 18, p.1
28 Health Legislation Amendment Bill 2014, cl.36 (new s.161A(1) of the *Hospital and Health Boards Act 2011*)
29 Health Legislation Amendment Bill 2014, cl.36 (new s.161A(2) of the *Hospital and Health Boards Act 2011*)
30 Health Legislation Amendment Bill 2014, cl.36 (new s.161A(3) of the *Hospital and Health Boards Act 2011*)
31 Health Legislation Amendment Bill 2014, cl.36 (new s.161B(2) of the *Hospital and Health Boards Act 2011*)

4 Amendments to the *Health Ombudsman Act 2013*

Section 30 of the *Health Ombudsman Act 2013* provides that the Health Ombudsman must consult and cooperate with other entities with functions that are relevant to, or may impact on, the Health Ombudsman's functions.

Section 30 provides that the entities the Health Ombudsman must consult and cooperate with includes the privacy commissioner under the *Right to Information Act 2009*.

Clause 17 of the Bill amends section 30 to clarify that the privacy commissioner is appointed under the *Information Privacy Act 2009*, and not the *Right to Information Act 2009.* The Queensland Law Society supported the amendment.[32]

Clause 18 amends section 228 to correct an incorrect reference to a subsection in that provision.

32 Queensland Law Society, Submission 26, p.1

5 Amendments to the *Mental Health Act 2000* – definition of *psychiatrist*

5.1 Introduction

The *Mental Health Act 2000* defines *psychiatrist* as:

- a person registered under the Health Practitioner Regulation National Law to practise in the medical profession as a specialist registrant in the speciality of psychiatry, other than as a student, or
- a person registered under the Health Practitioner Regulation National Law with limited registration to practise in an area of need in a specialist position in psychiatry.[33]

The Explanatory Notes state that AHPRA has introduced a new category of psychiatrist, namely limited registration for postgraduate training or supervised practice.[34]

5.2 Proposed amendment

Clause 41 of the Bill amends the definition of *psychiatrist* in the Schedule to the *Mental Health Act 2000* to include the following category of psychiatrist:

> *A person registered under the Health Practitioner Regulation National Law with limited registration to undertake postgraduate training in supervised practice in a specialist position in psychiatry.*

The Explanatory Notes state that "Failure to take account of the new category of limited registration may have considerable workforce and service delivery implications, as medical practitioners with this type of registration cannot [currently] undertake the functions of an authorised psychiatrist under the *Mental Health Act 2000*".[35]

The department advised that "The amendment will also avoid workforce and service delivery implications in areas of need to enable suitably qualified medical practitioners from countries such as Canada and the United Kingdom to undertake functions under the Mental Health Act, in particular in regional and remote Queensland".[36]

5.3 Submission

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) supported the amendment. RANZCP stated that it understands the amendment will ensure international medical graduates who do not qualify for general or specialist registration fall within the definition of *psychiatrist* under the legislation and is necessary to harmonise with recent changes to AHPRA categories.[37]

The Queensland Division of Occupational Therapy Australia also supported the amendment which it considered will further encourage development of Queensland's future mental health workforce.[38]

33 *Mental Health Act 2000*, Schedule
34 Explanatory Notes, p.5
35 Explanatory Notes, p.5
36 Dr Michael Cleary, Deputy Director-General, Health Service and Clinical Innovation, Queensland Health, *Public Briefing Transcript*, 10 September 2014, p.7
37 RANZCP, Submission 14, p.1
38 Occupational Therapy Australia – Queensland Division, Submission 25, p.3

6 Amendments to the *Public Health Act 2005* – civil liability for asbestos

6.1 Introduction

Under the *Public Health Act 2005* (the PH Act), local governments have responsibility for the administration and enforcement of a range public health risks related to asbestos.[39]

On 21 March 2013, the Queensland Ombudsman tabled *The Asbestos Report: An investigation into the regulation of asbestos in Queensland* (the Asbestos Report).[40] The report identified significant gaps and shortcomings in the regulation of asbestos in Queensland, including a lack of coordination and strategic planning by state agencies and councils responsible for responding to asbestos events.[41]

Recommendation 15 of the Asbestos Report proposed that the department work with councils to resolve whether asbestos should remain a local government public health risk as defined by the PH Act and take steps to implement an agreed approach.[42]

The Explanatory Notes state that the Government has sought to implement a more collaborative and integrated approach for managing and responding to asbestos-related risks in Queensland. The Explanatory Notes state that:

> *The Bill gives effect to this intent by addressing the protection from civil liability risks for asbestos-related matters – a key barrier that has prevented local government from being able to fully assume responsibility for the administration and enforcement of asbestos-related matters.*[43]

In his introductory speech, the Minister stated the Bill amends the PH Act:

> *… to transfer civil liability for asbestos related matters from local governments to the state. These amendments give effect to recommendations from the Asbestos Report: an investigation into the regulation of asbestos in Queensland. The amendments provide indemnity to local governments against civil liability for the management of asbestos related health risks in non-workplace settings. The protection only applies to specified local government officers who are acting in an official capacity under the Disaster Management Amendment Act. The indemnity is contingent upon local governments complying with a number of conditions including record keeping and staff training.*[44]

6.2 Protection from civil liability and indemnity

Section 456 of the PH Act currently provides that a *prescribed person* (in this instance, the Minister, chief executive of the department or a local government, and other officers) is not civilly liable for an act done, or omission made, honestly and without negligence under the PH Act.

If the *prescribed person* is a local government chief executive officer or a person authorised by a local government chief executive officer, the liability instead attaches to the local government.

39 Explanatory Notes, p.5

40 Queensland Ombudsman, *The Asbestos Report: An investigation into the regulation of asbestos in Queensland*, March 2013, http://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2013/5413T2307.pdf

41 Explanatory Notes, p.6

42 Queensland Ombudsman, *The Asbestos Report*, p.xi

43 Explanatory Notes, p.6

44 Hon. Lawrence Springborg MP, Minister for Health, 'Introductory Speech, Health Legislation Amendment Bill 2014', *Hansard*, Legislative Assembly of Queensland, 9 September 2014, p.2,972, http://www.parliament.qld.gov.au/documents/hansard/2014/2014_09_09_WEEKLY.pdf

The Explanatory Notes state that current section 456 "… will only indemnify prescribed persons in the absence of negligence, which is of little use for a claim against a prescribed person for an act or omission in relation to an asbestos-related risk if the claim involves negligence".[45]

The Bill inserts new section 454B(1) to make specific provision for immunity from civil liability for conduct which gives rise to *asbestos-related harm*.[46]

The amendment provides that a *prescribed person* (in this instance, the local government chief executive officer or person appointed or acting under the authorisation of the chief executive officer) is not civilly liable for official conduct engaged in by the person, if that conduct gives rise to *asbestos-related harm*. The Bill provides that any liability instead attaches to the relevant local government. The local government may recover a contribution from the prescribed person, if they acted other than in good faith and with gross negligence.

Clause 44 of the Bill omits section 456(3) of the PH Act and inserts a new section 456(3) and (4) to clarify that the general protection from civil liability at section 456 does not apply to a *prescribed person,* if the person is protected from civil liability in relation to *asbestos-related harm* under section 454B(1) or under section 26B(4) of the *Public Service Act 2008.*

6.3 Transfer of civil liability from local government to the State

6.3.1 Proposed amendments

New section 454C of the PH Act provides that a local government is indemnified by the State against any civil liability for official conduct of a *prescribed person* that gives rise to *asbestos-related harm*, if the local government has reasonably complied with certain conditions (new sections 454F to 454I) in relation to each *asbestos-related event*.[47]

Where a local government is indemnified by the State, the State assumes the rights of the local government in relation to the civil liability.

A local government is not, however, indemnified in relation to civil liability of the local government under the *Workers' Compensation and Rehabilitation Act 2003.*[48]

The amendments provide that where there is dispute about whether local government has reasonably complied with the conditions, the onus of proof is on the local government.

New section 454D provides that the State may recover a contribution from a local government for any liability indemnified under section 454C, if:

- the liability resulted from conduct that was engaged in other than in good faith and with gross negligence
- the local government engaged in conduct that it knew or should have known could prejudice the State's defence of a claim or a potential claim relating to the liability, or
- the local government did not reasonably cooperate with, and assist, the State to defend the claim that resulted in the liability.

New section 454D(5) provides that the amount of contribution recoverable by the State will be determined by the court.

45 Explanatory Notes, p.32

46 *Asbestos-related harm* is defined as harm that is, or is suffered because of, a dust-related condition within the meaning of the *Civil Liability Act 2003* that is attributable to asbestos (Health Legislation Amendment Bill 2014, cl.43, new s.454A of the *Public Health Act 2005*).

47 *Asbestos-related event* is defined as an event involving the exposure, release or dispersal or potential exposure, release or dispersal of asbestos fibres and related to the performance of a local government's asbestos-related function (Health Legislation Amendment Bill 2014, cl.43, new s.454A of the *Public Health Act 2005*).

48 Health Legislation Amendment Bill 2014, cl.43 (inserts new s.454E into the *Public Health Act 2005*)

The Explanatory Notes state the new provision "seeks to be consistent with contemporary civil liability provisions under the *Public Service Act 2008*".[49]

6.3.2 Support for transfer of civil liability to the State

The Local Government Association of Queensland (LGAQ) supports, in principle, the transfer of civil liability from local government to the State. At the public hearing, Mr Stephan Bohnen, LGAQ stated:

> *It [civil liability for asbestos related events] was one of the key barriers why until now local governments have been very reluctant to take on that role. That is a key barrier that has now been addressed.*[50]

6.3.3 Liability under workers compensation legislation

Logan City Council raised concerns that the proposed amendments do not cover civil liability under the *Workers' Compensation and Rehabilitation Act 2003*. It suggested that there were workplace health and safety risks to local government officers.[51]

The department advised that the amendments form one part of a package of assistance that the State Government is providing to local governments. It advised that the role of local government officers who administer the legislation does not involve asbestos removal, and that exposure to asbestos while administering the legislation in domestic settings would be extremely low to negligible. In addition, local government employees are already covered by mandatory workers' compensation.[52]

6.3.4 Local government assistance to defend claims

Logan City Council accepted that local government should provide assistance to the State in defending a claim. The Council considered, however, that assistance should be limited to providing appropriate briefs of evidence and expert testimony in court proceedings, and not extended to local government paying, or sharing legal costs incurred by the State in defending the claim.[53]

The department's response stated that it considers it reasonable that local governments assist the State with defending a claim, including incurring costs attached to that assistance. As only an estimated five percent of approximately 110 asbestos complaints each year are not minor in nature, the department does not anticipate that there will be large numbers of cases of civil liability, and the impact is expected to be minimal.[54]

6.4 Indemnity conditions

6.4.1 Proposed amendments

The Bill provides that a local government must comply with the conditions at new sections 454F to 454I in order to be indemnified by the State for an *asbestos-related event*. The local government must:

- ensure that an *authorised person* who exercises powers under the PH Act in relation to an asbestos-related event has satisfactorily completed the training prescribed by regulation[55]

49 Explanatory Notes, p.32
50 Mr Stephan Bohnen, Principal Advisor - Intergovernmental Relations, LGAQ, *Public Hearing Transcript*, 29 October 2014, p.16
51 Logan City Council, Submission 8, p.1
52 Dr Michael Cleary, Chief Operations Officer, *on behalf of* Mr Ian Maynard, Director-General, Department of Health, *Correspondence*, 3 November 2014, http://www.parliament.qld.gov.au/documents/committees/HCSC/2014/HLAB2014/cor-03Nov2014-doh.pdf
53 Logan City Council, Submission 8, p.1
54 Dr Michael Cleary, Department of Health, *Correspondence*, 3 November 2014
55 Health Legislation Amendment Bill 2014, cl.43 (new s.454G of the *Public Health Act 2005*)

- comply with the PH Act, any other laws relevant to an *asbestos-related event* and any guideline made by the chief executive of the department[56] about *asbestos-related events*
- ensure a record is kept about the *asbestos-related event* (including date of complaint, name and contact details of complainant, location of event, details of witnesses, action taken and measures implemented to remove or reduce public health risk and guidelines that were followed) for at least 70 years.[57]

The Explanatory Notes state the intent of the record keeping requirements are "… to require a local government to make and keep records about any actions and information relating to an asbestos-related event that will assist in defending any future claim".[58]

6.4.2 Reasonable compliance with indemnity conditions

Brisbane City Council sought clarification about the mechanism for determining whether a local government has "reasonably complied" with the indemnity conditions.[59]

In response, the department advised that proposed new sections 454F to 454I set out the conditions that a local government must meet for the State to indemnify it against any civil liability. The department noted that it is not unusual for legislation to apply a "reasonable test", and that the concept of "reasonable compliance",

> *… provides a form of protection for a local government that has failed to comply with a prescribed condition due to circumstances beyond its control. Where the State is not satisfied that the local government has reasonably complied with an indemnity condition, a court may consider and determine reasonable compliance.*[60]

6.4.3 Training and guidance

Brisbane City Council, Logan City Council and LGAQ welcomed the scheduled training on asbestos management to be provided by the department to local government officers starting in October this year.

At the public hearing, Mr Stephan Bohnen, LGAQ, stated that "I cannot stress enough the importance of continued accessibility for local government officers to ongoing and high quality training".[61]

Logan City Council sought assurances that the scheduled training will be prescribed by regulation under section 454G and that further training will be provided on a regular basis.[62] The LGAQ and Brisbane City Council sought clarification about how ongoing training on asbestos management will be supported; including how a council could request further training from the department.[63]

The department advised that the Government has made a commitment to an ongoing mechanism for the provision of training, and a sustainable mechanism to train local government officers such as an eLearning program is being explored.[64]

Logan City Council also sought assurances that local government would be consulted on any guidelines to be made by the chief executive of the department under section 454H, and be provided with sufficient time to provide comments.[65]

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56 A guideline made by the chief executive under s.454H(2) must be prescribed under a regulation and published on the department's website.
57 Health Legislation Amendment Bill 2014, cl.43 (new s.454I of the *Public Health Act 2005*)
58 Explanatory Notes, p.33
59 Brisbane City Council, Submission 7, p.1
60 Dr Michael Cleary, Department of Health, *Correspondence*, 3 November 2014
61 Mr Stephan Bohnen, LGAQ, *Public Hearing Transcript*, 29 October 2014, p.13
62 Logan City Council, Submission 8, p.1
63 LGAQ, Submission 20, p.2; Brisbane City Council, Submission 7, p.1
64 Dr Michael Cleary, Department of Health, *Correspondence*, 3 November 2014
65 Logan City Council, Submission 8, p.2

The committee was advised by the department that it will consult with local governments, through the LGAQ, during development of any guidelines made under new section 454H. Further, a proposed guideline would be subject to impact assessment under the Government's Regulatory Impact Statement System.[66]

6.4.4 Record keeping requirements

The LGAQ considers that 70 years is a significant period of time to require records to be kept about asbestos-related events and that the requirement will impose considerable costs on councils.[67] Brisbane City Council considers that the requirement to retain training and complaint records for 70 years is unreasonable and impracticable.[68]

The Explanatory Notes state that the reason for this:

> *… is because of the long latency period between exposure to asbestos and the diagnosis of an asbestos-related disease (up to 50 years). As such, there may be a significant time delay between the management of an asbestos-related event by local government and an affected party seeking compensation for damages.*[69]

The committee sought the department's response to this issue. The department reiterated the importance of taking account of the potentially long latency period for asbestos related diseases in its response to issues raised in submissions. Mesothelioma has an average latency period of 20 to 50 years after exposure and disease may develop up to 60 years after initial exposure. "The record keeping requirement must take account of this latency period and must also include a period to take account of possible anomalies or delays associated with the bringing of a claim. This is necessary to ensure the State can adequately defend a claim".[70]

The committee notes the LGAQ and Brisbane City Council's concerns. The committee considers, however, that the requirement to keep records for 70 years is proportionate given the long latency period between exposure to asbestos and diagnosis of an asbestos-related disease.

6.4.5 Annual compliance certificate

The Bill provides that a local government may give the chief executive of the department an annual compliance certificate about the local government's compliance with the indemnity conditions for one or more asbestos-related event that happened during the year.[71]

The certificate must be in the approved form, signed by the chief executive officer and verified by statutory declaration.[72] Where a chief executive receives an annual compliance certificate, the chief executive must give the chief executive officer of the local government a notice acknowledging receipt of the certificate.[73]

An annual compliance certificate is taken, in the absence of evidence to the contrary, as evidence of the matters stated in the certificate, providing that the certificate was given to the chief executive within two years after the end of the year to which it relates.[74]

The LGAQ suggested that the annual compliance certificate provisions will be an imposition of councils to varying degrees, depending on the size of the council. The LGAQ requested that the

66 Dr Michael Cleary, Department of Health, *Correspondence*, 3 November 2014
67 LGAQ, Submission 20, p.1
68 Brisbane City Council, Submission 7, p.1
69 Explanatory Notes, p.33
70 Dr Michael Cleary, Department of Health, *Correspondence*, 3 November 2014
71 Health Legislation Amendment Bill 2014, cl.43 (new s.454J of the *Public Health Act 2005*)
72 Health Legislation Amendment Bill 2014, cl.43 (new s.454J of the *Public Health Act 2005*)
73 Health Legislation Amendment Bill 2014, cl.43 (new s.454K of the *Public Health Act 2005*)
74 Health Legislation Amendment Bill 2014, cl.43 (new s.454L of the *Public Health Act 2005*)

content of the certificate be kept to a minimum and suggests that the department consider establishing and maintaining a portal that can be used by councils to update their registers online.[75]

In its response to submissions the department advised the committee that provision of an annual compliance certificate is not mandatory. The certificate would provide assurance and certainty to local government that they will be indemnified for asbestos-related events, rather than being required to verify that they have complied with the indemnity conditions during the assessment of a claim, possibly 40 or 50 years later. The department advised that a portal may be developed to assist local governments maintain an online register of records.[76]

6.5 Other issues raised in submissions

In its submission, Brisbane City Council stated that the amendments do not address all of the issues related to transitioning the administrative and enforcement responsibility for asbestos related public health risk in a domestic setting to local government. In particular, Brisbane City Council considers that the Bill fails to address:

- the significant workplace health and safety risks to local government officers investigating asbestos related public health risks
- additional funding to cover the extra workload for local governments
- the recovery of associated clean-up costs, especially where no remedial notice is able to be issued or where an alleged offender is unable to be identified.[77]

The LGAQ and Logan City Council also raised concerns about the adequacy of the cost recovery provisions in the PH Act to deal with asbestos clean-up costs. Logan City Council states it prefers the cost recovery provisions in the *Local Government Act 2009*.

The LGAQ and Logan City Council recommended that a standalone cost recovery fund be established for the recovery of asbestos clean-up costs, where the responsible party cannot be found or is unable to pay for site decontamination. The LGAQ suggested that a model similar to the Orphan Spill fund be established.[78]

The department advised the committee that cost recovery issues for asbestos clean-up where costs cannot be recouped by councils will be considered by Government in 2015 as part of further work about asbestos issues which is being led by the Department of Justice and Attorney-General.[79]

6.5.1 Committee comment

The committee considers that the suggestion that a stand-alone cost recovery fund be established for the recovery of asbestos clean-up costs is worthy of consideration. The committee understands that there is no legal barrier to local governments establishing such a fund, and suggests that the LGAQ and its members further consider establishment and administration of a standalone cost recovery fund for asbestos-related events. The committee also notes the department's advice that Government will further examine this issue in 2015.

75 LGAQ, Submission 20, p.2
76 Dr Michael Cleary, Department of Health, *Correspondence*, 3 November 2014
77 Brisbane City Council, Submission 7, p.1
78 Logan City Council, Submission 8, p.2; LGAQ, Submission 20, p.2
79 Dr Michael Cleary, Department of Health, *Correspondence*, 3 November 2014

7 Amendments to the *Radiation Safety Act 1999*

7.1 Renewal of expired Act instruments

The *Radiation Safety Act 1999* (RS Act) provides that a person must not possess, use, transport, acquire or dispose of a radiation source unless they hold an appropriate Act instrument.[80] Certain Act instruments may be renewed on application from the instrument holder; such instruments are defined as *renewable Act instruments*. Renewable Act instruments are:

- a licence
- an accreditation certificate
- a continuing approval to acquire a radiation source
- a radiation safety officer certificate.

Section 79 of the RS Act provides that an application for the renewal of a renewable Act instrument must be made within the period starting 60 days before the instrument expires. Once the Act instrument has expired, an application for a new Act instrument must be made.

The department advised that "There were 7,618 instruments of renewal applied for between 1 July 2013 and 30 June 2014. Ninety-three per cent of these renewals were received before the expiry date; seven per cent of these were received 30 days or less from the expiry date".[81]

Clause 49 inserts new subsection 1(A) into section 79 of the RS Act to provide that the chief executive may accept an application for renewal of a *renewable Act instrument*, if the application is made within 30 days after the instrument ended, if the chief executive considers it reasonable to do so.

The amendments to section 79 include the following examples of when it may be reasonable for the chief executive to accept a late application:

- a failure or delay in sending the application by post that the holder could not have reasonably foreseen
- an unforeseen medical condition preventing the holder applying for the renewal before the term of the instrument ends.

The Explanatory Notes state that:

> *Allowing the renewal of Act instruments up to 30 days after they have expired is considered less burdensome on holders of Act instruments than having to apply for a new Act instrument. Allowing for the renewal of recently expired Act instruments is consistent with the approach taken in other jurisdictions, and under other Queensland legislation.*[82]

7.2 Banned radiation sources

As outlined above, the RS Act prohibits a person from possessing a radiation source unless the person is authorised under a possession licence. The RS Act also prohibits a person from acquiring a radiation source unless the person is a possession licensee for the source and has an approval to acquire the source.

The RS Act also provides that a person is prohibited from possessing, supplying or using a radiation source that is prescribed under regulation as a *banned radiation source*.

The Explanatory Notes state that some individuals may try to circumvent the prohibition on banned radiation sources, prescribed under regulation, by applying for a possession licence and/or an

80 Explanatory Notes, p.6
81 Dr Michael Cleary, *Public Briefing Transcript*, 10 September 2014, p.7
82 Explanatory Notes, p.14

approval to acquire a *banned radiation source*. In these circumstances, the application would be made to the chief executive and his or her decision could be the subject of an appeal.[83]

Clause 48 inserts new section 50A into the RS Act to clarify that a person may not apply for, and the chief executive may not issue, an Act instrument for a *banned radiation source*.

7.3 Banned radiation practices

Section 47A of the RS Act provides that a person who possesses a *prescribed radiation source* must not allow a radiation practice to be carried out that exposes another person prescribed under a regulation to radiation emitted from the source in circumstances prescribed under a regulation.

A *prescribed radiation source* is defined as a solarium or another radiation source prescribed under a regulation.

The Explanatory Notes state that "At present, this prohibits commercial operators of solaria from allowing minors, or persons with a certain skin type, to access a solarium".[84]

The amendments to the Radiation Safety Regulation 2010, however, which banned the use of commercial solaria in Queensland after 31 December 2014, will make the references to solarium in the definition of *prescribed radiation source* redundant.

Accordingly, clause 47 amends the definition of *prescribed radiation source* at section 47A of the RS Act to remove the references to solarium.

7.4 Records of the former Radiological Advisory Council

Clause 50 inserts new section 236 into the RS Act to provide that the ownership of documents, for example council minutes and agenda papers, of the former Radiological Advisory Council of Queensland transfer to the current Radiation Advisory Council.

7.5 Submissions

The Royal Australian and New Zealand College of Radiologists supports the amendments.[85] The committee notes that most of the amendments are minor, and that the amendment to provide for renewal of expired instruments is similar to legislation in other jurisdictions.[86]

83 Explanatory Notes, p.7
84 Explanatory Notes, p.7
85 Royal Australian and New Zealand College of Radiologists, Submission 24, p.1
86 Explanatory Notes, p.22

8 Amendments to the *Tobacco and Other Smoking Products Act 1998* – smoking bans in correctional facilities and around health facilities and schools

Smoking tobacco is recognised as one of the largest preventable causes of death and disease in Australia. Each year, smoking kills an estimated 15,000 Australians and costs Australia $31.5 billion in social (including health) and economic costs.

The Australian Government and state and territory governments, through the Council of Australian Governments, have committed by 2018, to reduce the national adult daily smoking rate to 10 per cent and halve the Aboriginal and Torres Strait Islander adult daily smoking rate (from 47 per cent in 2008).[87]

Australian has some of the most stringent tobacco control legislation in the world. A summary of the current tobacco control measures at the Commonwealth level and in Queensland is at Appendix D.

In his introductory speech on the Bill, the Minister stated:

> *While Queensland has some of the strongest tobacco legislation in Australia, there is community support for the laws to go further. The bill amends The Tobacco Act to extend smoking bans on and around health facilities, school grounds and in prisons.*[88]

8.1 Correctional facilities

The Corrective Services Regulation 2006 prohibited smoking in all public and private correctional facilities from 5 May 2014.

Clause 57 of the Bill removes section 26R(2)(d) of the Tobacco Act, which excludes smoking in secure correctional facilities from the ban on smoking in enclosed spaces, to reflect the provisions in the Corrective Services Regulation 2006.

8.1.1 Submissions

The Queensland Law Society (QLS) does not support this amendment. The QLS states it has received reports that the smoking ban in correctional facilities "has caused unintended and needless disruption in secure facilities". The QLS recommended that the ban be reconsidered or "consideration be given to establishing support mechanisms, at a practical level, for smokers in secure facilities".[89]

The committee asked the department for its response. The department confirmed that the smoking ban in correctional facilities has been in place since May 2014. In developing strategies to support prisoners to cease smoking, the department and the Department of Justice and Attorney-General drew on the successful experience with prison smoking bans in the Northern Territory and New Zealand.

> *Key strategies to support implementation of smoking bans include increased access to nicotine replacement therapy (NRT) for prisoners; staff quit smoking program; education and communication about smoking bans; tailored assistance from correctional facility health and medical staff, including responding to individual clinical or other needs of offenders with existing health conditions and related medications. To assist with implementation, an independent external review of QCS facilities 'state-of-readiness'*

87 Department of Health (Cwlth), *Tobacco Control*, 10 June 2014, accessed 8 October 2014, http://www.health.gov.au/tobacco

88 Hon. Lawrence Springborg MP, Introductory Speech, Health Legislation Amendment Bill 2014, p.2,971

89 Queensland Law Society, Submission 26, p.1

> *was undertaken by a New Zealand Corrections Manager who was previously involved in New Zealand implementation.*[90]

8.1.2 Committee comment

The committee supports the amendment which ensures that the Tobacco Act is consistent with the Corrective Services Regulation. The committee understands that support mechanisms are already in place for prisoners who smoked. At the committee's public briefing, the department advised the committee that:

> *The transition to smoke-free prisons went very smoothly. Over 80 per cent of offenders who smoke access nicotine replacement therapy to help their craving and potential irritability.*[91]

8.2 Banning smoking on and around health facilities and schools

8.2.1 Current prohibitions

The Tobacco Act prohibits smoking in all enclosed places, including enclosed areas of health facilities and schools.[92] The HHB Act prohibits smoking on public health service land, including a hospital, community health centre, health clinic or rehabilitation centre, other than in a nominated smoking place.[93]

Under the HHB Act, the chief executive of a Hospital and Health Service may establish a *nominated smoking place* within the grounds of a health facility. Smoking in outdoor areas of schools is currently regulated by policy.[94]

8.2.2 Proposed amendments

The Bill amends the Tobacco Act and the HHB Act to remove the discretion to nominate smoking places at health facilities and ban smoking on, and within five metres of, a public or private health facility and state and non-state schools.[95]

At the public briefing, the department advised the committee that "Smoke-free schools, hospitals and related facilities reinforce the message that those institutions have an important place for learning, care and the promotion of healthy living".[96]

The Explanatory Notes state that the amendments will also address the issue of smokers gathering near the entry to health facilities and schools, forcing visitors, staff and children to move through and be exposed to environmental tobacco smoke.[97]

At the public hearing, the department advised that:

> *Progressively, our healthcare facilities in Queensland—public and private—have most definitely moved to being non-smoking. There has been a policy response first, then supported by legislation backed by very strong community support. This is the next step …*[98]

90 Dr Michael Cleary, Department of Health, *Correspondence*, 3 November 2014
91 Dr Michael Cleary, *Public Briefing Transcript*, 10 September 2014, p.3
92 *Tobacco and Other Smoking Products Act 1998,* s.26R
93 *Hospital and Health Boards Act 2011*, s.184
94 Explanatory Notes, p.9
95 Health Legislation Amendment Bill 2014, cls.37 and 59
96 Dr Michael Cleary, *Public Briefing Transcript*, 10 September 2014, p.2
97 Explanatory Notes, p.9
98 Mr Mark West, Director, Preventative Health Unit, Queensland Health, *Public Hearing Transcript*, 29 October 2014, p.22

8.2.3 Application of the smoking ban

Sections 26ZGC and 26ZGD provide that is an offence, attracting a maximum of 20 penalty units ($2,200), to smoke on, or within five metres of, *health facility land*[99] or *school land*[100].

The prohibition on smoking within five metres of the boundary of health facility or school land does not apply to:

- residential premises – a premises used, or intended to be used, as a place of residence or mainly as a place of residence
- business premises – a premise used for a commercial or industrial activity, or
- a person in a motor vehicle, unless the vehicle is parked on a road or road-related area.[101]

Section 26ZGE provides that a person who smokes on, or within five metres of, health facility or school land must comply with a direction to stop smoking by an *authorised person*. A person who does not comply with such a direction commits an offence attracting a maximum of 20 penalty units ($2,200).

8.2.4 Submissions

The QLS stated that the proposed new section 26ZGD(3) and the current section 26R may cause confusion and calls for "further consideration and examination of these causes [sic] and the intent of the exemption".[102]

In response, the department advised that proposed section 26ZGD(3), located in Part 2C, new Division 2A of the Tobacco Act provides an exemption to the prohibition for circumstances where the non-smoking buffers around a school extends into an enclosed area of a neighbouring workplace or business. Smoking bans in enclosed areas are in Part 2B of the Act.

> *This conflict between the buffer zones and enclosed places is resolved under clause 59 of the Bill, which clarified – in new section 26ZGA – that the new Division 2A does not apply to enclosed places. As stated in the explanatory notes for clause 59, the intent is [sic] of new section 26ZGA is 'to provide clarity about the provision under which a person commits an offence for smoking in an enclosed place on health facility land or school land'.*[103]

8.2.5 Enforcement of smoking ban by authorised persons

Section 28 of the Tobacco Act provides for the appointment of an *authorised person* to exercise certain powers under the Act.

Clause 61 amends section 28 of the Tobacco Act to enable the chief executive of a HHS to appoint a person (a *health service authorised person*) to investigate, monitor and enforce compliance with the smoking ban on and around health facilities within their health service area.

In performing his or her functions, a *health service authorised person* may:

- require a name and address from a person committing a smoking offence
- direct a person to stop smoking.

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99 *Health facility land* is defined as land on which a private health facility (as defined in the *Private Health Facilities Act 1999*) is situated and land on which a Hospital and Health Service provides a health service.

100 *School land* is defined as land on which a State school provides an educational program; land on which a non-State school provides primary, secondary or special education; or land on which a State or non-State school provides other educational instruction or activities.

101 Health Legislation Amendment Bill, cl.59

102 Queensland Law Society, Submission 26, pp.1-2

103 Dr Michael Cleary, Department of Health, *Correspondence*, 3 November 2014

The Bill also provides that it is an offence for a person: to provide false or misleading information to an authorised person; for a person to give a false, misleading or incomplete document to an authorised person; and to impersonate an authorised person and to obstruct an authorised person.

Submissions and department's advice

The Queensland Catholic Education Commission (QCEC) sought clarification about the appointment of an *authorised person* to investigate, monitor and enforce the smoking ban on and around school land. The QCEC assumed that an *authorised person* in a school setting would be the principal or person appointed by the principal.

The LGAQ raised concerns that the proposed bans on and around hospitals and schools will cause funding and resource issues for councils, as there will be an expectation from the community that councils will enforce the new rules.[104] The department was asked to respond and advised that:

- *authorised persons* under the Tobacco Act have authority to enforce offences, including issuing 'on-the-spot' fines and using other regulatory powers
- *authorised persons* for enforcement of smoking bans at schools is proposed to include: environmental health officers and police officers, who can enforce the ban on school land and in the buffer areas beyond the boundary; and authorised local government officers of councils that elect to take up the option to enforce, who can ban in the buffer
- adding an enforcement responsibility to the workload of principals and teachers is not supported. Principals and teachers will be able to encourage compliance by asking people to stop smoking and move on, which is in line with current policy and does not create an additional regulatory burden on school principals
- local government can liaise with Hospital and Health Services to identify areas in the community that require targeted enforcement by Public Health Unit enforcement officers in lieu of local governments.[105]

8.2.6 Support for the smoking ban on and around health facilities and schools

A significant number of submissions, including the Australian Medical Association Queensland, Cancer Council, National Stroke Foundation – Queensland, The Royal Australian and New Zealand College of Radiologists, National Heart Foundation of Australia and the Lung Foundation of Australia support the extension of the smoking ban to on, and around, health facilities and schools.[106]

8.2.7 Concerns about impact – on and around health facilities and schools

The Private Hospital Association Queensland (PHAQ) and Townsville HHS raised concerns about the smoking ban on and around health facility land.

At the public hearing, Ms Lucy Fisher, PHAQ stated that:

> *As healthcare providers, obviously, we strongly support initiatives to reduce smoking rates within the community. However whilst the intent of the legislation may seem a logical next step along the road to the reduction in smoking rates and measures to minimise exposure to tobacco smoke, we believe that there needs to be some caution*

104 LGAQ, Submission 20, p.2

105 Dr Michael Cleary, Department of Health, *Correspondence*, 3 November 2014

106 Royal Australasian College of Physicians – Queensland State Committee (RACP), Submission 1, Submission 1; Cancer Council Queensland, Submission 2; Queensland Catholic Education Commission, Submission 3; Mr Phil Browne, Submission 5; National Heart Foundation of Australia, Submission 13; Quit Victoria, Submission 15; Australian Medical Association Queensland, Submission 16; Royal Australasian College of Surgeons – Queensland Regional Committee, Submission 17; National Stroke Foundation – Queensland, Submission 19; Lung Foundation Australia, Submission 23, p.1; Royal Australian and New Zealand College of Radiologists, Submission 24, p.1

> *that, in introducing this legislation, it does not create some other adverse effects. So our concerns are centred solely on the practical management of the proposal*.[107]

The PHAQ considers that the current discretionary power for health facilities to nominate smoking places is preferable, as it provided an effective balance between the competing priorities of:

- accommodating the rights and special needs or vulnerable patients who may be smokers – in particular, palliative or mental health patients who may be unable or prevented from leaving the health facility to smoke
- minimising the potential for increased legal and health and safety risks for patients and staff – requiring patients and staff to leave the facility to smoke would increase the risk of harm, particularly after dark
- acknowledges the impact on local residents whose properties adjoin the health facility – the establishment of an exclusion zone will lead to a congregation of smokers outside their property.[108]

Townsville HHS stated that the amendments would mean that the HHS will be liable to manage a significant number of patients and elderly residents who need to escorted by staff off the health facility to smoke. The HHS considered this would have significant staffing implications and expose residents, patients and staff to an increased risk of falls and further harm.[109]

The PHAQ also raised concerns about the proposed implementation date of 1 January 2015. The PHAQ questioned whether the implementation date would provide the department with sufficient time to provide health facilities with guidance and advice on the implementation of the ban. The PHAQ also considers that the implementation date provides insufficient time to assess the impact on patient medication levels of sudden cessation of smoking.[110]

At the public hearing, Dr Cleary advised that:

> *The important thing there is for alternatives to be offered to patients around options for them during their stay in hospital. That can be a variety of products such as nicotine patches, gum and so on. That deals with the dependency component and is quite an effective mechanism in terms of the management of patients while they are in hospital*.[111]

8.2.8 Committee comment

The committee notes the concerns raised by PHAQ and Townsville HHS about the impact of the smoking ban on and around health facility land on vulnerable patients. The committee recommends that the Minister ensure that the department works with the HHSs and private health facilities to ensure that appropriate nicotine replacement therapy products are made available to relevant patients during their stay at a health facility.

Recommendation 2

The committee recommends that the Minister for Health ensure that the Department of Health work with Hospital and Health Services and private health facilities to ensure that appropriate nicotine replacement therapy products are made available to patients during their stay in a health facility.

107 Ms Lucy Fisher, Executive Director, PHAQ, *Public Hearing Transcript*, 29 October 2014, p.4
108 PHAQ, Submission 6, p.3
109 Townsville HHS, Submission 18, p.2
110 PHAQ, Submission 6, p.5
111 Dr Michael Cleary, Deputy Director-General, Health Service and Clinical Innovation Division and Chief Operations Officer, Queensland Health, *Public Hearing Transcript*, 29 October 2014, p.22

The committee acknowledges the concerns raised about potential increased legal and health and safety risks for staff at health facilities. The committee considers, however, that any practical issues raised by the ban are not insurmountable, and that those issues are outweighed by the public health benefits from banning smoking in health facilities.

8.3 Support for further extension of smoking bans in Queensland

The Cancer Council Queensland, Mr Browne, National Heart Foundation of Australia, Quit Victoria, and Lung Foundation Australia recommended that the Government further extend the smoking ban.[112]

The submitters recommended that the smoking ban be extended to bus stops, ferry terminals, taxi ranks, train stations, pedestrian malls, the grounds of TAFEs and Universities, outdoor markets, footpaths and within ten metres of council buildings, playgrounds and sports stadia. The National Heart Foundation of Australia also called for the removal current exemption from the smoking ban for premium gaming rooms and designated outdoor smoking areas in licenced premises.[113]

The department advised the committee that government may consider further reform in future. It advised of the following smoking bans, and powers of local government to regulate smoking:

- smoking is banned at railway stations under the Transport Infrastructure (Railway) Regulation 2006 and at busway stations in Brisbane under the Transport Infrastructure (Busway) Regulation 2002
- local governments are empowered to regulate smoking at public transport waiting points and malls; the intent of the power to enable local governments to make local laws to ban smoking at malls and public transport waiting points is for local assessment of community needs and the extent to which smoking is problematic, and to choose to make local laws if the public benefit outweighs the costs of enforcement
- policy could be used to regulate smoking, e.g. QUT policy prohibits smoking in areas at campuses and QUT has committed to moving toward a smoke-free environment.[114]

8.3.1 Committee comment

The committee notes that section 26ZPA to 26ZPE of the *Tobacco and Other Smoking Products Act 1998* provide that a local government may make a local law prohibiting smoking at an outdoor public transport waiting point or outdoor pedestrian malls in their area.

Witnesses at the public hearing informed the committee that very few local governments have made local laws prohibiting smoking. The committee asked the LGAQ for information about local government prosecutions; it advised that to its knowledge three councils had made local laws and the practice regarding prosecutions varied between councils.[115] In response to the committee's request to respond to issues raised in submissions, the department noted the "minimal use of the authority to make local laws" and advised that Ipswich City has smoke-free malls and bus stops, the Queen Street Mall in Brisbane is non-smoking, Redlands City Council has banned smoking at specific transport waiting points and Fraser Coast Regional Council has banned smoking at bus and taxi stops, zones, seats, shelters and waiting points.

The committee recommends a review of local government's current use of the power at sections 26ZPA to 26ZPE of the *Tobacco and Other Smoking Products Act 1998* to ban smoking at public

112 Cancer Council Queensland, Submission 2; Mr Phil Browne, Submission 5; National Heart Foundation of Australia, Submission 13; Quit Victoria, Submission 15; Lung Foundation Australia, Submission 23

113 National Heart Foundation of Australia, Submission 13, p.3

114 Dr Michael Cleary, Department of Health, *Correspondence*, 3 November 2014

115 Mr Greg Hoffman PSM, Acting Chief Executive Officer, LGAQ, *Correspondence – Responses to Questions taken on Notice*, 5 November 2014, http://www.parliament.qld.gov.au/documents/committees/HCSC/2014/HLAB2014/cor-05Nov2014-lgaq.pdf

transport waiting points and outdoor pedestrian malls. Should it be considered that the current use of these powers is ineffective in protecting the public from harm caused by smoking, the committee recommends that the Minister consider introducing a state-wide smoking ban at outdoor pedestrian malls, transport waiting points and other areas frequented by the public.

Recommendation 3

The committee recommends that the Minister for Health ask the Department of Health to:

- review local government's current use of the power at sections 26ZPA to 26ZPE of the *Tobacco and Other Smoking Products Act 1998* to ban smoking at public transport waiting points and outdoor pedestrian malls
- if current regulation by local government is deemed inadequate to protect the public from harm, consider introducing a state-wide smoking ban at public transport waiting points and outdoor pedestrian malls
- consider extending existing and proposed smoking bans to outdoor areas frequented by the public, including, for example, TAFE colleges.

9 Amendments to the *Tobacco and Other Smoking Products Act 1998* – applying existing tobacco laws to personal vaporising devices

9.1 Introduction

Personal vaporiser devices (also known as electronic cigarettes, 'vape pens', 'e-shisha', or alternative/electronic nicotine delivery devices) are designed as an alternative to tobacco smoking. The devices are sometimes marketed as an option to help people quit smoking, or as a tobacco replacement.[116] They do not contain tobacco leaf, require combustion, or produce cigarette smoke.

Personal vaporiser devices deliver an aerosol by heating a fluid that users inhale into the lungs. The main constituents of the fluid are nicotine (when nicotine is present), propylene glycol (with or without glycerol) and flavourings.[117]

Some devices are shaped to look like conventional tobacco products (for example, cigarettes, cigars, cigarillos, pipes or hookahs); however, they also take the form of everyday items such as pens, USB memory sticks and larger cylindrical or rectangular devices.[118] Devices may be disposable, rechargeable or refillable.

The Explanatory Notes advise that despite differences in design, each device typically consists of a battery, an electronic heating element, and a cartridge or refillable 'tank' containing chemicals such as propylene glycol, vegetable glycerine, liquid nicotine, and flavourings. Users of these devices experience the same deep inhalation of substances into the lungs as cigarettes.[119]

The Therapeutic Goods Administration (TGA) advises that:

> *Unlike Nicotine Replacement Therapy (NRT) products [nicotine patches, gum etc.], which have been rigorously assessed for efficacy and safety, and, therefore, approved by the Therapeutic Goods Administration for use as aids in withdrawal from smoking, no assessment of electronic cigarettes has been undertaken and, therefore, the quality and safety of electronic cigarettes is not known.*[120]

The WHO reports that use of personal vaporiser devices is "apparently booming". It is estimated that in 2014, there were 466 brands and that in 2013 US$ 3 billion was spent on the devices globally. Sales of vaporisers are forecasted to increase by a factor of 17 by 2030.[121]

In the rest of this chapter, personal vaporiser devices are referred to as vaporisers.

9.2 Current regulation of nicotine, objects resembling tobacco products and nicotine replacement therapy products

The following regulations, at the State and Commonwealth level, already apply, to varying degrees, to the importation, sale and use of vaporisers in Queensland.

116 Department of Health (Cwlth), Therapeutic Goods Administration, *Electronic cigarettes*, 12 March 2013, www.tga.gov.au/consumers/ecigarettes.htm

117 World Health Organisation (WHO) Framework Convention on Tobacco Control, *Electronic nicotine delivery systems*, Agenda Paper for Conference of the Parties to the WHO Framework Convention on Tobacco Control, Sixth Session, Moscow, Russian Federation, 13-18 October 2014, p.2, http://apps.who.int/gb/fctc/PDF/cop6/FCTC_COP6_10-en.pdf?ua=1

118 WHO Framework Convention on Tobacco Control, *Electronic nicotine delivery systems*, p.2

119 Explanatory Notes, p.8

120 Department of Health (Cwlth), Therapeutic Goods Administration, *Electronic cigarettes*

121 WHO Framework Convention on Tobacco Control, *Electronic nicotine delivery systems*, p.2

9.2.1 Prohibition of liquid nicotine

It is an offence in Queensland, under the Health (Drugs and Poisons) Regulation 1996, for a person to manufacture, obtain, possess, prescribe, dispense, sell, use or destroy nicotine, without authorisation or an approval. The offence attracts a maximum penalty of $9,108.[122]

The committee understands that a person was convicted in Cairns recently for possession and advertising of liquid nicotine contained in vaporisers. The person was fined $2,500.[123]

9.2.2 Prohibition of objects resembling tobacco products

Section 26ZS of the *Tobacco and Other Smoking Products Act 1998* prohibits the sale of objects that resemble tobacco products. The offence attracts a maximum penalty of 140 penalty units ($15,400). The Act specifies that an object resembles a tobacco product if it:

- has an appearance that is likely to cause a reasonable person to consider the object resembles a tobacco product or tobacco product package
- is contained in a package that is likely to cause a reasonable person to consider the package resembles a tobacco product package, or
- is declared under a regulation to resemble a tobacco related product or tobacco product package (no objects have currently been declared under such a regulation.

In Western Australia, the Supreme Court ruled that a person in Perth, who was selling electronic cigarettes online, was guilty of breaching the *Tobacco Products Control Act 2006* (WA) by selling a product designed to resemble a cigarette. The WA Health Department has stated that the Supreme Court judgement confirms its position that the sale of electronic cigarettes is prohibited in WA.[124]

The department considers, however, that the current restrictions do not "adequately cover all product types or address issues about the use of personal vaporisers in public places".[125]

The committee notes that clause 60 amends section 26ZS to provide that a vaporiser is exempt from this provision.

9.2.3 Regulation of therapeutic goods – Therapeutic Goods Administration

Products claiming to help people to quit smoking are classified as therapeutic goods. The importation and supply (including sale) of therapeutic goods is illegal in Australia unless authorised by the Therapeutic Goods Administration (TGA).

Nicotine Replacement Therapy (NRT) products, for example, nicotine patches, gum, lozenges, inhalers and mouth spray, are classified as therapeutic goods. They have been assessed for efficacy and safety and approved by the TGA for use as aids in withdrawing from smoking.[126]

The department advised that:

> *The safety, quality and effectiveness of e-cigarettes as quit-smoking aids remain unproven … There is no benefit in the devices to assist people to stop smoking. There are, however, six types of TGA approved nicotine replacement devices or products that are available, including patches, gum, lozenges, inhalers, mouth sprays, mouth strips et*

122 Queensland Health, *Electronic Cigarettes,* 11 September 2014, accessed 22 October 2014, http://www.health.qld.gov.au/public-health/topics/atod/tobacco-laws/electronic-cigarettes/default.asp

123 The Australian, *Qld man fined for selling e-cigarettes*, 10 July 2014, http://www.theaustralian.com.au/news/latest-news/qld-man-fined-for-selling-e-cigarettes/story-fn3dxiwe-1226984769775?nk=f2dcdba4104c5a59597bd21991d01d8e

124 Department of Health (WA), *Fine sends warning on e-cigarettes sales*, accessed 31 October 2014, http://www.health.wa.gov.au/press/view_press.cfm?id=1431

125 Explanatory Notes, p.8

126 Department of Health (Cwlth), Therapeutic Goods Administration, *Electronic cigarettes*, www.tga.gov.au/consumers/ecigarettes.htm

> *cetera. They are already available and they are available for people to access should they wish to quit smoking.*[127]

It is, therefore, illegal in Australia to import and supply (including sale) vaporisers that claim to be therapeutic goods and smoke cessation aids, as they have not been authorised by the TGA. The committee notes, however, that most manufacturers and distributors of vaporisers do not explicitly claim to help people to stop smoking in order to circumvent these rules.

Recent media reports indicate that British American Tobacco has made approaches to have its devices reviewed by the TGA in order to sell its products in Australia as smoke cessation aids.[128]

9.3 Proposed regulation of personal vaporisers and associated products

The Explanatory Notes state that:

> *The intent is not to prohibit personal vaporisers from sale, or impose restrictions on contents or design (for example, look, nicotine presence, fluid contents or flavourings), but to provide a regulatory approach that treats these devices in the same way as other tobacco and smoking products.*[129]

9.3.1 Definition of personal vaporiser and personal vaporiser related product

Clause 53 of the Bill inserts a definition of *personal vaporiser* as a device that:

> *(a) is capable of being used to deliver nicotine into an individual's body when the individual inhales through the device; and*
>
> *(b) has 1 or more of the following parts-*
> *(i) a battery;*
> *(ii) a cartridge or container to store a liquid, vapour or gas;*
> *(iii) an electric heating element.*[130]

The term *personal vaporiser related product* is defined as any of the following products:

> *(a) a device or other product that-*
> *(i) is apparently intended to be part of a personal vaporiser; and*
> *(ii) is not capable of being used to deliver nicotine into an individual's body without adjustment, modification or addition;*

The Bill gives the examples of an atomiser, battery, cartridge, container or mouthpiece or a product that combines an atomiser and cartridge in a single unit.

> *(b) a device or other product to which paragraph (a) does not apply that is apparently intended to be used in connection with a personal vaporiser.*

The example in the Bill is a liquid that is to be used in a vaporiser, whether or not the liquid is in a cartridge or container.

The Bill also provides that the Minister may prescribe by regulation that any other product that is used primarily to smoke with a vaporiser is to be considered *personal vaporiser related product.*[131]

New section 5A provides that a bong, hookah or ice pipe is not a *personal vaporiser* or *personal vaporiser related product*.

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127 Dr Michael Cleary, *Public Briefing Transcript*, 10 September 2014, p.2

128 'Big tobacco pushes e-cigarettes as 'medicine'', *7.30*, Australian Broadcasting Corporation, Reporter: Conor Duffy, 2 October 2014, http://www.abc.net.au/7.30/content/2014/s4099507.htm

129 Explanatory Notes, p.15

130 Health Legislation Amendment Bill 2014, cl.53 (new s.5A of the *Tobacco and Other Smoking Products Act 1998*)

131 Health Legislation Amendment Bill 2014, cl.53 (new s.5A of the *Tobacco and Other Smoking Products Act 1998*)

The Explanatory Notes state that the above definitions are intended to exclude items of a similar nature that are not intended to be used as a personal vaporiser, such as an asthma puffer.[132] The department advised that "Medical devices approved by the TGA will not be captured by this proposed amendment, for example ventolin puffers".[133]

Submissions

The National Heart Foundation of Australia, National Stroke Foundation, and Quit Victoria urged the Government to ensure that the definition of *personal vaporiser* applies to all non-nicotine vaporisers.[134] Quit Victoria questioned whether disposable non-nicotine electronic cigarette products, which by design cannot be taken apart for the purpose of adding any other liquid, including nicotine, would be covered by the definition of *personal vaporiser*.[135]

The department's response to submissions advised that the policy intent was to capture all personal vaporisers, regardless of whether they contain nicotine, and that the definition in the Bill will be further considered.

The committee agrees with submitters that the definition of *personal vaporiser* must cover all of the various forms of device, without also inadvertently capturing devices such as ventolin puffers, and notes the complexity of defining the products that are to be regulated. The committee therefore recommends that the definitions in the Bill be amended.

Recommendation 4

The committee recommends that the Bill be amended to ensure that the definitions of *personal vaporiser* and *personal vaporiser related product* capture all of the vaporiser devices and products which are intended to be regulated.

9.3.2 Restrictions on advertising, display, promotion, supply and use in smoke-free places

In his introductory speech, the Minister stated that the:

> *… proposal is a 'same rules apply' approach rather than totally prohibiting personal vaporisers.*[136]

Clauses 56 and 67 amend the definition of *smoking products* for the purpose of Part 1 (Preliminary), Part 2 (Supply of smoking products), Part 2A (Advertising, display and promotion of smoking products) and Part 3 (Monitoring and enforcement) of the Tobacco Act to include *personal vaporisers* and *personal vaporiser related products*.

Clause 67 amends the definition of *smoke* for the purpose of the Tobacco Act to include inhaling through a vaporiser.

The effect of the amendments is to provide that the current rules in relation to cigarettes and other tobacco products use in smoke-free places, supply, advertising, display and promotion apply to *personal vaporisers* and *personal vaporiser related products*.

In summary, the amendments:

- prohibit the sale and supply of vaporisers and related products to children (under 18 years of age)

132 Explanatory Notes, p.35
133 Dr Michael Cleary, *Public Briefing Transcript*, 10 September 2014, p.2
134 National Heart Foundation of Australia, Submission 13; Quit Victoria, Submission 15; National Stroke Foundation – Queensland, Submission 19
135 Quit Victoria, Submission 15, pp.1-2
136 Hon. Lawrence Springborg MP, Introductory Speech, Health Legislation Amendment Bill 2014, p.2,972

- require suppliers to take action to help prevent the sale and supply of vaporisers and related products to children, and to ensure their employees do not supply them to children
- prohibit the sale of vaporisers and related products from tobacco vending machines
- prohibit the display, and restrict advertising, of vaporisers and related products from retail outlets
- prohibit the promotion of vaporisers and related products through competitions, giveaways and by supplying other products that promote them
- prohibit the use of vaporisers in smoke-free enclosed places, smoke-free motor vehicles and smoke-free outdoor places (including hospitals, schools and correction services)
- provide an exemption for vaporisers and related products from the prohibition from selling products that resemble tobacco products.[137]

9.4 Rationale for the regulation of *vaporisers*

In his introductory speech, the Minister stated that:

> *This amendment aims to protect the years of campaigning by governments and communities to denormalise smoking. There is no doubt that many of these personal vaporisers are certainly being used as an introductory process for people, and particularly children, into the very bad and life-limiting habit of smoking.*[138]

The department advised that because personal vaporisers do not contain tobacco leaf, they are not automatically covered by existing tobacco laws, and there are no restrictions relating to their sale and supply, promotion, use or enforcement. The Explanatory Notes state that:

> *Their unregulated availability to children, retail advertising and display, and use in smoke-free public places risks a return to smoking becoming popular and desirable especially to youth. Years of campaigning by governments and communities to 'de-normalise' smoking and reduce smoking rates could be undermined by the sale and use of electronic cigarettes and other personal vaporisers.*[139]

The department advised that:

> *The changes for the electronic cigarettes, or e-cigarettes, are about taking early action now to protect the health of Queenslanders.*

and

> *The public health concerns about those devices include concerns that existing laws for smoke-free zones do not capture e-cigarette use. People, and in particular children, may be exposed to the second-hand-and I use the word in inverted commas-'smoke' from the e-cigarettes.*[140]

The Explanatory Notes state that "The scientific evidence regarding short- and long-term health effects of direct or indirect (second-hand) inhalation of vapour from personal vaporising devices remains inconclusive".[141]

9.4.1 World Health Organisation report

The department advised that the World Health Organisation (WHO) "has also called for strong regulation in relation to the devices. Therefore, the changes today are clearly in keeping with the international perspective on e-cigarettes".[142]

137 Explanatory Notes, p.15
138 Hon. Lawrence Springborg MP, Introductory Speech, Health Legislation Amendment Bill 2014, p.2,972
139 Explanatory Notes, p.8
140 Dr Michael Cleary, *Public Briefing Transcript*, 10 September 2014, p.2
141 Explanatory Notes, p.9
142 Dr Michael Cleary, *Public Briefing Transcript*, 10 September 2014, p.2

The WHO Framework Convention on Tobacco Control report, for discussion at its conference in October 2014, identified the following issues and possible health risks from e-cigarettes.

- risks from nicotine inhalation: different devices deliver different amounts, user puffing behaviour may lead to overdose through unreliable dosage delivered by devices
- nicotine is addictive and can have negative effects on cardiovascular system, pregnant women and young people
- possible nicotine poisoning (mainly to children) due to leakage from devices or nicotine containers that are not child-proof
- health risks to non-users from inhalation of second hand e-cigarette aerosol – bystanders are exposed to exhaled nicotine and particles from e-cigarettes. However, it is accepted that the levels emitted would be lower than conventional cigarette emissions
- efficacy in helping smokers to quit is unknown as only a few studies have examined this aspect. No e-cigarette product has been evaluated and approved as a smoking cessation by a government agency, despite many manufacturers making this claim
- concerns of a 'gateway' to smoking and 'renormalisation' of smoking. There is considered to be a possibility that children and non-smokers will start to use e-cigarettes and develop a nicotine addiction that may lead them to switch to cigarette smoking.[143]

Queensland Health's website states that vaporisers may also contain unknown, possibly toxic chemicals and have incorrect or inconsistent labelling and unsafe packaging.[144]

9.5 Support for the regulation of *vaporisers*

The Explanatory Notes state that "Applying existing *Tobacco and Other Smoking Product Act 1998* provisions to personal vaporising devices is in line with community expectations for the protection from products that produce smoke and vapour in the manner of smoking".[145]

A significant number of submissions support the proposals to apply existing tobacco regulation to e-cigarettes.[146]

Dr Coral Gartner, Research Fellow at The University of Queensland, Centre for Clinical Research commends the "same rules apply" approach, rather than a total prohibition on the sale and use of vaporisers. At the public hearing, Dr Gartner informed the committee of the results of a recent survey she had conducted of current vaporiser uses. Dr Gartner stated that:

> *Applying an age restriction to the sale of personal vaporisers was supported by most of the participants—90 per cent of them agreed with that-and around half of those surveyed opposed applying the same restrictions on the sale of personal vaporisers as on tobacco products. However, compared to other options such as banning domestic sales, there was strong opposition to that and there was also very strong opposition to restricting sales to pharmacies or on prescription. In terms of restrictions on public use of personal vaporisers, 35 per cent of respondents thought that there should be no restrictions on where personal vaporisers could be used. However, I think it is important to note that more than half actually supported having some restrictions on public vaping*

143 WHO Framework Convention on Tobacco Control, *Electronic nicotine delivery systems*, pp.3-6

144 Queensland Health, *Electronic Cigarettes*, 29 September 2014, accessed 22 October 2014, http://www.qld.gov.au/health/staying-healthy/atods/smoking/devices/index.html

145 Explanatory Notes, p.9

146 Royal Australasian College of Physicians – Queensland State Committee, Submission 1; Cancer Council Queensland, Submission 2; Queensland Catholic Education Commission, Submission 3; Mr Phil Browne, Submission 5; PHAQ, Submission 6; Dr Coral Gartner, Submission 11; National Heart Foundation of Australia, Submission 13; Quit Victoria, Submission 15; Australian Medical Association Queensland, Submission 16; Royal Australasian College of Surgeons – Queensland Regional Committee, Submission 17; National Stroke Foundation – Queensland, Submission 19; Lung Foundation Australia, Submission 23; The Royal Australian and New Zealand College of Radiologists, Submission 24; and Queensland Law Society, Submission 26

> *but they did not want as many restrictions as are currently applied to smoking cigarettes.*[147]

Dr Gartner stated that electronic cigarettes may have an important role in reducing health risks for smokers who choose to use electronic cigarettes as a replacement.[148]

At the public hearing, Dr Gartner stated that:

> *It is a very sensible compromise to regulate these products [vaporisers] similar to tobacco products because you eliminate those main concerns that people in the tobacco control area have which is about inappropriate promotion to young people, advertising and selling to young people that may make smoking and vaping like a very mainstream activity, but it would still allow this product [vaporisers] to be used by people who may need it and may benefit from it.*[149]

Dr Gartner stated that the ban on the use of electronic cigarettes outdoors may be difficult to justify on public health grounds. Dr Gartner advised that the risk posed by exposure to bystanders outdoors is likely to be trivial or non-existent compared to cigarettes and is substantially less than traffic and exhaust fume pollution. Dr Gartner acknowledged, however, the challenges that may arise from enforcing different restrictions for the outdoor use of cigarettes and electronic cigarettes.[150]

The National Heart Foundation of Australia, Quit Victoria, and the Queensland Branch of the National Stroke Foundation welcomed the inclusion of vaporisers which do not contain nicotine. They considered that the health impacts of non-nicotine vaporisers are largely unknown and the availability of flavoured liquids, such as chocolate and strawberry, encourages smoking behaviour in children and young adults.[151] Quit Victoria recommended that the Bill go further by prohibiting the sale of all non-nicotine electronic cigarettes in the absence of approval by the TGA.[152]

9.6 Opposition to the proposed regulation of vaporisers

The Peregrine Corporation argued that it is unreasonable and disproportionate to impose a legislative scheme designed to control tobacco products to vaporisers which do not contain nicotine. At the public hearing, Ms Luu-Nguyen, Peregrine Corporation, stated:

> *… we think that products that do not contain nicotine should be treated in a way that is proportionate to their risk profile and we do not necessarily think that they should be subject to the same regulatory framework that imposes the same restrictions that would otherwise apply to a more harmful product that does contain nicotine and the like.*[153]

In its submission, the Peregrine Corporation stated that:

- the Health (Drugs and Poisons) Regulation 1996 which prohibits sale, possession etc. of liquid nicotine, without statutory approval, already provide an adequate regulatory framework for managing nicotine products, including vaporisers containing liquid nicotine
- the issue is a failure to enforce the Health (Drugs and Poisons) Regulation 1996 which has led to widespread illegal trade in retail outlets and on the internet

147 Dr Coral Gartner, Research Fellow, The University of Queensland, Centre for Clinical Research, *Public Hearing Transcript*, 29 October 2014, p.2
148 Dr Coral Gartner, Submission 11, p.2
149 Dr Coral Gartner, *Public Hearing Transcript*, 29 October 2014, p.7
150 Dr Coral Gartner, Submission 11, p.2
151 National Heart Foundation of Australia, Submission 13; Quit Victoria, Submission 15; National Stroke Foundation – Queensland, Submission 19
152 Quit Victoria, Submission 15, p.1
153 Ms Thuy Luu-Nguyen, Corporate Lawyer, Peregrine Corporation, *Public Hearing Transcript*, 29 October 2014, p.3

- there is no legitimate epidemiological, medical, health or legal basis on which to impose strict legislative regime on the sale, supply and promotion of vaporisers which do not contain nicotine. The Tobacco Act already imposes restrictions on the sale and supply of such products, if they seek to resemble or mimic tobacco products
- it supports the views of 53 world health authorities who wrote to WHO to argue vaporisers should be considered as part of the harm reduction strategy
- the Bill fails to adequately address the issue of absence of product standards to regulate the quality of products, for example ingredients; quality or grade of ingredients; standardised labelling and health or other warning labels
- the definition of *personal vaporiser* is too vague and difficult to enforce – 'capable of being used to deliver nicotine' could cover devices that are modified by user for nicotine use, against the original intent of the manufacturer.[154]

Clubs Queensland considers that vaporisers should be able to be used in all parts of a club's premise at the discretion of club management, and not be restricted to use only in designated outdoor smoking areas.[155]

Clubs Queensland submitted that the amendments would inadvertently cause more harm than good, people who seek to reduce or quit smoking will 'vape' in areas designed for traditional smokers and will be exposed to second hand smoke. Clubs Queensland also stated that the amendments are inconsistent with other jurisdictions and will cause problems for clubs, especially on the New South Wales border. Clubs Queensland recommends that the regulation of electronic cigarettes should be dealt with at national level to ensure a national standardised legislative framework.[156]

The department advised the committee that while a consistent national legislative approach would be ideal, Queensland does not intend to delay regulating electronic cigarettes, and noted that other jurisdictions may follow Queensland's lead.[157]

9.7 Committee comment

The committee notes that given their recent introduction to the market, other Australian jurisdictions and countries are still considering how to best regulate the use of vaporisers. A summary of the approach to regulating vaporisers in other Australia jurisdictions and internationally is at Appendix E.

The committee supports the 'same rule applies' approach adopted by the Government for the regulation of vaporisers.

The committee notes Peregrine Corporation and Clubs Queensland's concerns about the regulation of non-nicotine devices and the potential positive role for vaporisers as part of a harm reduction strategy for smokers of cigarettes and other tobacco products. The committee supports Dr Gartner's view that the proposed regulation of vaporisers would not prevent vaporisers playing a full and effective role in any harm reduction strategy for current cigarette smokers.

The committee acknowledges the current lack of evidence to conclusively demonstrate the harm caused – both direct and indirect – by the use nicotine and non-nicotine vaporisers and whether vaporisers could be a 'gateway' product for future cigarette smoking. The committee considers, however, that it is appropriate for the Government to take precautionary steps now to protect Queenslanders from the potential harm from using vaporisers, rather than to wait until the supporting evidence becomes available.

154 Peregrine Corporation, Submission 4, pp.1-3
155 Clubs Queensland, Submission 12, pp.1-3
156 Clubs Queensland, Submission 12, pp.1-3
157 Dr Michael Cleary, Department of Health, *Correspondence*, 3 November 2014

The committee recommends that the Minister review the regulation of vaporisers, as proposed in the Bill, as and when evidence becomes available on the potential harm caused by the use of nicotine and non-nicotine vaporisers.

Recommendation 5

The committee recommends that, if evidence becomes available on the potential harm caused by the use of nicotine and non-nicotine vaporisers, the Minister for Health initiate a review the regulation of vaporisers, as proposed in the Bill.

The committee shares the Peregrine Corporation's concerns about the current lack of prescribed standards for vaporisers and related devices, including ingredients, nicotine levels and delivery dosages and tamper proof measures (such as child proof devices and containers). The committee also notes that vaporisers will not, under the proposals in the Bill, be required to include health warnings.

The committee recognises that product standards for vaporisers and health warnings would be most appropriately dealt with at a national level. Accordingly, the committee recommends that the Minister work with his colleagues on the Health Council of the Council of Australian Government (COAG) to urgently introduce statutory product standards for vaporisers and a requirement for all vaporisers and packaging to contain health warnings and instructions on safe use of the device.

The committee recommends that, in considering this matter, the Minister takes note of the Food and Drug Administration (FDA) in the United States of America's proposal to require manufacturers of vaporisers to register with the FDA product and ingredient listings. The committee also recommends the Minister consider the European Union's recent amendments to its Tobacco Products Directive. The amendments prescribe maximum nicotine concentration levels for vaporisers and volumes for cartridges and containers and require the use of high purity ingredients, the use of child and tamper proof devices and the display of health warnings and instructions on use on packaging.

Recommendation 6

The committee recommends that the Minister for Health work with his colleagues in the Health Council of the Council of Australian Governments to urgently introduce statutory product standards for all personal vaporiser devices and a requirement for all vaporisers and packaging to contain health warnings and instructions on the safe use of the device.

10 Amendments to the *Transplantation and Anatomy Act 1979* – supply arrangements for blood and tissue based products

10.1 Introduction

The *Transplantation and Anatomy Act 1979* (Transplantation and Anatomy Act) provides for "… the removal of human tissues for transplantation, for post-mortem examinations, for the definition of death, for the regulation of schools of anatomy, and for related purposes".[158]

10.2 Proposed amendments

The Bill amends the Transplantation and Anatomy Act to:

- remove controls on the buying, selling and advertising of blood products and human tissue which potentially obstruct national blood supply arrangements and the supply of tissue based therapeutic products approved by the TGA
- clarify that third parties contracted by the Commonwealth or Queensland to supply blood and blood products are able to buy, advertise and sell those products in Queensland
- clarify that tissue based therapeutic products included on the Australian Register of Therapeutic Goods can be bought, sold and advertised in Queensland
- clarify that where there is inconsistency between the Transplantation and Anatomy Act and the *Research Involving Human Embryos and Prohibition of Human Cloning for Reproduction Act 2003* about reimbursing donor expenses, the latter Act prevails
- allow the Minister to delegate functions, including the power to approve an advertisement relating to the buying of tissue or the right to take tissue, to an appropriate official.[159]

10.3 Regulation of advertisements relating to buying of tissue

10.3.1 Current regulation

Section 41 of the Transplantation and Anatomy Act provides:

> *A person shall not -*
> *(a) publish or disseminate by newspaper, other periodical, book, broadcasting, television, cinematograph or other means whatever; or*
> *(b) exhibit to public view in a house, shop or place; or*
> *(c) deposit in the area, yard, garden or enclosure of a house, shop or place;*
>
> *an advertisement relating to the buying of tissue or of the right to take tissue from the bodies of persons unless the proposed advertisement has been approved by the Minister and contains a statement to that effect.*[160]

Acting contrary to section 41 is an offence that attracts a maximum penalty of 10 penalty units ($1,100) or three months imprisonment.

The term *tissue* is defined as an organ, blood or part of a human body or a human foetus or a substance extracted from an organ, blood or part of a human body or a human foetus. The term does not include immunoglobulins or laboratory reagents or reference and control materials, derived wholly or in part from pooled human plasma.[161]

158 *Transplantation and Anatomy Act 1979*, s.1
159 Hon. Lawrence Springborg MP, Introductory Speech, Health Legislation Amendment Bill 2014, p.2,972
160 *Transplantation and Anatomy Act 1979*, s.41
161 *Transplantation and Anatomy Act 1979*, s.4

10.3.2 Submissions

The Queensland Fertility Group (QFG) and Mr Stephen Page, a surrogacy lawyer, raised concerns about the impact of the regulation of advertising of tissue on patients seeking or receiving fertility treatment. The QFG stated that IVF units do not support the amendments to section 41 of the Transplantation and Anatomy Act.[162] QFG recommended that section 41 of the Transplantation and Anatomy Act be deleted rather than amended, for the following reasons:

- there is no evidence that advertising in relation to donor gametes in Queensland needs regulation
- most advertising is web and electronically based, making its access and distribution difficult to police and control
- many advertisements are generated by the community and individual patients, rather than corporate entities
- the majority of Australian jurisdictions do not regulate advertising for donor gametes
- the provision of donor gametes is essential for patients with significant and serious infertility, and
- neither advertising, nor acceptable and non-acceptable advertising, is defined in the Transplantation and Anatomy Act.[163]

Mr Page questioned whether the current drafting of section 41 gives the power to the Minister to regulate the advertising of sperm donors. Mr Page agrees with the QFG that section 41 imposes unnecessary bureaucratic approval process that increases costs and has little public benefit. Mr Page considers that the restrictions on advertising are detrimental and given the shortage of egg and sperm donors in Australia, everything must be done to enable people to donate.[164]

The department advised that the advertising approval requirement in section 41 of the Transplantation and Anatomy Act applies to advertising for sperm donors as sperm is captured by the meaning of *tissue* in the Act. The department noted that Queensland is one of four jurisdictions that regulate the advertising of human tissue.[165]

The committee sought the department's advice on the effect of section 41 of the Transplantation and Anatomy Act on people who seek or receive fertility treatment and may wish to advertise for eggs or sperm. The department advised the committee that, to minimise the potential impact on patients who seek or receive fertility treatment and wish to advertise for a gamete donor, it has developed criteria for assessment of advertisements. Those criteria are made available to anyone who applies for approval of an advertisement. To reduce the time taken for approval of advertisements, the department will work with applicants to adapt proposed advertisements to better meet the criteria before forwarding the application for consideration.[166]

10.3.3 Committee comment

The committee notes that section 41 of the Transplantation and Anatomy Act applies to advertising relating to buying and taking of all human tissue (as defined in section 4 of the Transplantation and Anatomy Act), not just eggs and sperm. For example, section 41 would apply to advertising relating to buying organs such as kidneys (however trade in such tissue is also prohibited). The committee considers that it is still appropriate for advertisements for certain human tissue to be approved by the Minister or his or her delegate.

The committee considers that timely processing of approvals will be important for people undertaking fertility treatment who seek eggs or sperm. The proposed amendments should result in

162 QFG, Submission 9, p.1
163 QFG, Submission 9, pp.1-2
164 Mr Stephen Page, Submission 22, p.2
165 Dr Michael Cleary, Department of Health, *Correspondence*, 3 November 2014
166 Dr Michael Cleary, Chief Operations Officer and Deputy Director-General, Health Service and Clinical Innovation, *on behalf of* Mr Ian Maynard, Director-General, Department of Health, *Correspondence*, 6 November 2014, http://www.parliament.qld.gov.au/documents/committees/HCSC/2014/HLAB2014/cor-06Nov2014-doh.pdf

a timely process for approving advertisements, given that the power to approve an advertisement may be delegated by the Minister.

The committee notes that advertising has changed substantially over the years, and that the regulation of internet advertising is complex. It is possible that there would be difficulties in enforcement of the existing advertising requirements in relation to advertisements by individuals who seek sperm or eggs for fertility treatment.

The committee also notes that regulation of advertising of human tissue should, to the greatest extent possible, be consistent across Australia.

The committee considers that more detailed examination is warranted of the current requirement for approval of altruistic non-commercial advertisements for sperm and egg donors. The committee, therefore, recommends that the Minister examine the possibility of removing the requirement for approval of advertising for gametes in altruistic non-commercial arrangements, and that the Minister raise the issue with counterparts in other jurisdictions through the Health Council of the Council of Australian Governments.

Recommendation 7

The committee recommends that the Minister for Health:

- examine the options for amendment of section 41 of the *Transplantation and Anatomy Act 1979* to remove the requirement for approval of advertisements for altruistic non-commercial advertising for sperm or eggs for fertility treatment
- with a view to achieving a nationally consistent approach to advertising, raise the issue with health ministers in other jurisdictions through the Health Council of the Council of Australian Governments.

11 Fundamental legislative principles

Section 4 of the *Legislative Standards Act 1992* states that 'fundamental legislative principles' are the 'principles relating to legislation that underlie a parliamentary democracy based on the rule of law'. The principles include that legislation has sufficient regard to:

- the rights and liberties of individuals
- the institution of Parliament.

The committee considered the application of fundamental legislative principles to the Bill.

11.1 Access to patient identifying information – rights and liberties of individuals

Clause 36 of the Bill inserts new section 161A into the HHB Act to provide that the chief executive may authorise an external service provider, or a person engaged by an external service provider, to access a Queensland Health information system.

The accessing of personal, private and confidential patient information by a third party external service provider or their agent raises obvious implications for the rights of patients whose information is actually accessed or is potentially accessible.

As outlined in section 3.4, the committee notes that the Bill includes a number of safeguards to protect patient information. For example, the chief executive must authorise access in writing (which may include conditions) and be satisfied that access is necessary for an external service provider to provide a health service. An external service provider who has been authorised to access a Queensland Health information system will also be bound by the National Privacy Principles.

Given the proposed safeguards, the committee considers that, on balance, clause 36 has sufficient regard to the rights and liberties of individuals.

11.2 Root cause analysis in a prescribed health service facility – immunity from civil liability – rights and liberties of individuals

Section 4(3)(h) of the *Legislative Standards Act 1992* provides that legislation should not confer immunity from proceeding or prosecution without adequate justification.

Clause 32 amends section 116 of the HHB Act to provide that RCA team members or relevant persons (for example, administrators and advisors) commissioned to conduct a RCA for health service provided by a *prescribed health service facility* (including non-government organisations) are protected from liability associated with a civil claim, defamation, breach of confidentiality and disciplinary action.

The committee considers that, on balance, clause 32 has sufficient regard to the rights and liberties of individuals. In reaching this view, the committee notes that RCA team members are appointed on a voluntary basis, protection from liability is only provided if an individual acted honestly and without negligence, and liability attaches instead to the entity which appointed the RCA team, thereby providing an avenue of legal redress for the aggrieved person.

11.3 Authorised persons to enforce smoking ban on school land – delegation of administrative power – rights and liberties of individuals

Section 4(3)(c) of the *Legislative Standards Act 1992* provides that legislation should allow the delegation of administrative power only in appropriate cases and to appropriate persons.

Clause 59 amends the Tobacco Act to prohibit smoking on health facility land and school land. New section 26ZGE provides that a person who smokes on health facility or school land must comply with a direction to stop smoking by an *authorised person*. Clause 64 amends section 40A of the Tobacco Act to permit an authorised person who finds a person smoking on health facility or school land to direct the person to stop smoking.

Clause 61 amends section 28 of the Tobacco Act to permit a health service chief executive to appoint a *health service authorised person* as an *authorised person* with the functions of investigating, monitoring and enforcing compliance with the smoking ban on health facility land.

The Bill does not specifically provide for an *authorised person* to enforce the smoking ban on school land. Given that failure by a person to comply with a stop smoking direction from an authorised person is an offence (maximum penalty of 20 penalty units), the committee sought clarification from the Minister about who would have the authority to issue such a direction on school land.

The Committee sought clarification about the appointment of, and delegation of power to, an *authorised person* to enforce the smoking ban on school land. The department advised that *authorised persons* for enforcement of smoking bans at schools are proposed to include environmental health officers and police officers who can enforce the ban on school land and in the area beyond the boundary, and authorised local government officers of councils that elect to enforce the smoking ban in the buffer area.[167]

The Minister, in his response to the committee's questions about fundamental legislative principles, advised that on school grounds, enforcement action (issuing of fines) will be undertaken by environmental health officers, employed by Hospital and Health Services. Environmental health officers are appointed as an *authorised person* under the Tobacco Act if the chief executive or delegate is satisfied that the person possesses the required expertise and experience for appointment under Queensland public health legislation. Appointees have tertiary qualifications in environmental health, and enforcement of smoking bans on school land is an extension of the current powers of authorised officers under the Tobacco Act.[168]

11.4 Transfer of civil liability for asbestos-related events from local government to the State – onus of proof – rights and liberties of individuals

Clause 43 inserts new section 454C into the PH Act to provide that a local government is indemnified by the State against any civil liability for official conduct of a prescribed person that gives raises to asbestos-related harm, if the local government has 'reasonably complied' with the indemnity conditions at new sections 454F to I.

New section 454C(3) provides that the onus of proving a local government has 'reasonably complied' with the indemnity conditions is on the local government. Section 4(3)(d) of the *Legislative Standards Act 1992* provides that legislation should not reverse the onus of proof in criminal proceedings without adequate justification.

The committee considers that the records by which a local government would seek to prove it had reasonably complied with the indemnity conditions would be internal and potentially confidential records of the local government. The committee, therefore, considers that it is reasonable that the local government be required to produce those records to establish its compliance, particularly as the local government is the party seeking to be indemnified for its potential costs or losses.

Accordingly, the committee considers that, on balance, clause 43 has sufficient regard to the rights and liberties of individuals.

11.5 Transfer of civil liability for asbestos-related events from local government to the State – immunity from civil liability – rights and liberties of individuals

Section 4(3)(h) of the *Legislative Standards Act 1992* provides that legislation should not confer immunity from proceeding or prosecution without adequate justification.

167 Dr Michael Cleary, Department of Health, *Correspondence*, 3 November 2014

168 Hon. Lawrence Springborg MP, Minister for Health, *Correspondence*, 10 November 2014, http://www.parliament.qld.gov.au/documents/committees/HCSC/2014/HLAB2014/cor-10Nov2014-minister.pdf

As outlined above, clause 43 provides that a prescribed person is not civilly liable for official conduct engaged in by the person that gives rise to asbestos-related harm.

The committee notes that new section 454B provides that where a prescribed person is deemed not to be civilly liable, the liability attaches instead to the local government, thereby providing an avenue of legal redress for the aggrieved person. The committee considers that given the length of time taken for asbestos-related harm to materialise (the mesothelioma latency period may be up to 60 years), it is appropriate for civil liability to shift from an individual person to the local government. The committee considers this provision should help an aggrieved person to make a civil claim, which in some cases may not be until a significant time after the asbestos-related event.

The committee considers that it is unusual for legislation to grant immunity to a person regardless of their level of potential negligence or possible lack of good faith. The committee notes, however, that a local government to whom liability has shifted may recover a contribution from the prescribed person, if the person's official conduct occurred with gross negligence or other than in good faith.

Accordingly, the committee considers that, on balance, clause 43 has sufficient regard to the rights and liberties of individuals.

11.6 Transfer of civil liability for asbestos-related events from local government to the State – clear and precise drafting – rights and liberties of individuals

Section 4(3)(k) of the *Legislation Standards Act 1992* provides that legislation should be unambiguous and drafted in a sufficiently clear and precise way.

Clause 43 inserts new section 454D into the PH Act to provide that the State may recover a financial contribution from a local government for liability indemnified under section 454C(1), but only if the circumstances stated in subsection (2), (3) or (4) exists.

The committee understands that this is a reference to subsection (2), (3) or (4) of 454D. The committee considers, however, that the positioning of the references to the circumstances stated in subsection (2), (3) or (4) immediately after a reference to section 454C(1) may raise doubt about whether the reference is a reference to subsections (2), (3) or (4) of section 454C or section 454D.

The committee wrote to the Minister on 31 October 2014 about the potential ambiguity of this provision. The Minister, in his response dated 10 November 2014, acknowledged the committee's concerns about new section 454D and confirmed that the intent is to enable the State to recover a contribution from the local government for liability indemnified under section 454C(1), but only if the circumstances in section 454D(2), (3) or (4) exist. The Minister advised that the department had consulted with the Office of the Queensland Parliamentary Counsel and, despite the provision conforming to drafting standards, it is agreed that the provision could be amended to remove the ambiguity.[169]

Recommendation 8

The committee recommends that the Bill be amended to remove the potential ambiguity in drafting of proposed new section 454D, inserted by clause 43, so there is no doubt about the circumstances in which the State may recover a financial contribution from a local government for a liability indemnified under proposed new section 454C.

169 Hon. Lawrence Springborg MP, Minister for Health, *Correspondence*, 10 November 2014

11.7 Entities exempt from restrictions on buying, advertising and selling human tissue – institution of Parliament

Clause 72 inserts new section 424B into the Transplantation and Anatomy Act to provide that an entity which is a party to an agreement with the Commonwealth or State for the buying or selling of tissue and is prescribed by regulation is exempt from the restrictions on buying, advertising or selling tissue.

Section 4(4)(a) of the *Legislative Standards Act 1992* provides that legislation should allow the delegation of legislative power only in appropriate cases and to appropriate persons. Section 4(4)(b) of the *Legislative Standards Act 1992* provides that legislation should only authorise the amendment of Act by another Act.

The Explanatory Notes state that the potential infringement is justified on the basis that prescribing an entity in regulation is necessary to allow third parties to identify which entities are exempt. The Explanatory Notes stated that "Due to commercial confidentiality, it would otherwise be difficult for third parties to identify which entities are party to an agreement with the Commonwealth or the State for the buying or selling of tissue".[170]

The committee considers that, on balance, clause 72 has sufficient regard to the institution of Parliament.

170 Explanatory Notes, p.19

Appendices

Appendix A – List of Submissions

Sub #	Submitter
001	The Royal Australasian College of Physicians – Queensland State Committee
002	Cancer Council Queensland
003	Queensland Catholic Education Commission
004	Peregrine Corporation
005	Mr Phil Browne
006	Private Hospitals Association of Queensland
007	Brisbane City Council
008	Logan City Council
009	The Queensland Fertility Group
010	Torres and Cape Hospital and Health Service
011	Dr Coral Gartner
012	Clubs Queensland
013	National Heart Foundation of Australia
014	The Royal Australian and New Zealand College of Psychiatrists – Queensland Branch Committee
015	Quit Victoria
016	Australian Medical Association Queensland
017	Royal Australasian College of Surgeons – Queensland Regional Committee
018	Townsville Hospital and Health Service
019	National Stroke Foundation – Queensland
020	Local Government Association of Queensland
021	Queensland Ambulance Service
022	Mr Stephen Page
023	Lung Foundation Australia
024	The Royal Australian and New Zealand College of Radiologists
025	Occupational Therapy Australia – Queensland Division
026	Queensland Law Society
027	Children's Health Queensland Hospital and Health Service

Appendix B – Witnesses at public briefing

Public briefing – Wednesday 10 September, Brisbane
Department of Health • Dr Michael Cleary, Deputy Director-General, Health Service and Clinical Innovation • Ms Loretta Carr, Manager, Regulatory Policy Unit • Ms Sophie Dwyer, Executive Director, Health Protection Directorate, Chief Health Officer Branch • Mr Mark West, Director, Preventative Health Unit, Chief Health Officer Branch

Appendix C – Witnesses at public hearing

Public hearing – Wednesday 29 October, Brisbane
University of Queensland, Centre for Clinical Research • Dr Coral Gartner, Research Fellow
National Heart Foundation of Australia (Queensland) • Ms Alison Durham, Advocacy Manager • Ms Rachelle Foreman, Health Director
Peregrine Corporation • Ms Thuy Luu-Nguyen, Corporate Lawyer
Private Hospitals Association Queensland • Ms Lucy Fisher, Executive Director
Local Government Association of Queensland • Mr Stephan Bohnen, Principal Advisor – Intergovernmental Relations
Queensland Fertility Group • Dr David Molloy, Medical Director
Department of Health • Dr Michael Cleary, Deputy Director-General, Health Service and Clinical Innovation • Ms Loretta Carr, Manager, Regulatory Policy Unit • Ms Sophie Dwyer, Executive Director, Health Protection Directorate, Chief Health Officer Branch • Mr Mark West, Director, Preventative Health Unit, Chief Health Officer Branch

Appendix D – Current Commonwealth and Queensland tobacco control measures

Commonwealth tobacco control measures

At the Commonwealth level, tobacco control measures include:

- tobacco plain packaging legislation
- a prohibition on publishing or broadcasting tobacco advertisements (including internet and electronic advertising) – exceptions include political discourse, anti-smoking advertisements, tobacco trade communications and point of sale advertisements (which are regulated by the states and territories)
- a requirement that health warnings cover at least 75 per cent of the front of most tobacco packaging, 90 per cent of the back of cigarette packaging and 75 per cent of the back of most other tobacco product packaging
- investment in anti-smoking social marketing campaigns
- a 25 per cent increase in tobacco excise
- a four-staged increase in excise and excise-equivalent customs duty on tobacco and tobacco-related products
- a reduction in duty free concessions for tobacco products
- stronger penalties for tobacco smuggling offences.[171]

The Commonwealth has also negotiated a voluntary agreement for the disclosure of the ingredients of cigarettes with three tobacco companies, Philip Morris Limited, British American Tobacco Australia Limited, and Imperial Tobacco Australia Limited. Under the agreement, the companies provide annual reports to the Government about cigarette ingredients. The data is published unmodified on the Department of Health's website.[172]

Commonwealth legislation bans smoking in all Commonwealth government buildings, aircraft, airports, interstate trains, and federally registered motor coaches.[173]

Queensland tobacco control measures

In Queensland, the *Tobacco and Other Smoking Products Act 1998*:

- prohibits the supply of tobacco and other smoking products to children (person aged under 18)
- regulates the location and content of tobacco vending machines
- specifies minimum saleable quantities of smoking products (for example, prohibited from selling cigarettes in packets containing less than 20 cigarettes)
- regulates the promotion, point of sale advertising and display of tobacco products.

Smoking is permitted only in residential premises and accommodation, designated outdoor smoking areas in licensed premises and premium gaming rooms. Smoking is banned:

- in all enclosed public (i.e. non-residential) spaces, including pubs, hotels, clubs, workplaces and restaurants
- in specific outdoor public places – patrolled beaches, children's play equipment, public outdoor swimming pools, sport stadia
- within four metres of public building entrances
- commercial outdoor eating and drinking venues
- in a motor vehicle being used for business use if anyone else is in the vehicle or if a child under the age of 16 is in the vehicle[174]

171 Department of Health (Cwlth), *Tobacco Control*

172 Department of Health (Cwlth), *Australian cigarette ingredient disclosure,* accessed 8 October 2014, http://www.health.gov.au/internet/main/publishing.nsf/Content/tobacco-ingred

173 Department of Health (Cwlth), *Environmental tobacco smoke*, accessed 8 October 2014, http://www.health.gov.au/internet/main/publishing.nsf/Content/tobacco-envt

- in all public and private correctional facilities (from 5 May 2014).[175]

Premises holding a commercial hotel or community club licence and casinos may designate up to 50 per cent of the licensed outdoor area as *designated outdoor smoking areas*. No gaming machines are to be located in the *designated outdoor smoking areas* and no food or drink is to be served and no food consumed in the area. Areas must have buffers that are impervious to smoke on perimeters.[176]

Local government may make local laws prohibiting smoking in a public transport waiting point that is not enclosed (including taxi ranks, ferry terminals and bus stops) or an outdoor pedestrian mall.[177] The committee notes that Brisbane City Council has used this power to ban smoking in the Queens Street Mall shopping precinct.

174 *Tobacco and Other Smoking Products Act 1998*, ss.26Q to 26ZL
175 Corrective Services Regulation 2006
176 *Tobacco and Other Smoking Products Act 1998*, ss.26ZA and 26ZB
177 *Tobacco and Other Smoking Products Act 1998*, ss.26ZPA to 26ZPE

Appendix E – Approaches to the regulation of personal vaporising devices

Other Australian jurisdictions

No other Australian jurisdiction has, to date, enacted legislation similar to that proposed in the Bill.

The Explanatory Notes state that all states and territories prohibit liquid nicotine under poisons regulations. South Australia, New South Wales, the Northern Territory, and Western Australia have general provisions in state-based tobacco legislation that prohibits the sale of objects resembling tobacco products.[178]

In Western Australia, the Supreme Court ruled that a person in Perth, who was selling vaporisers online, was guilty of breaching the *Tobacco Products Control Act 2006* by selling a product designed to resemble a cigarette. The WA Health Department has stated that the Supreme Court judgement confirms its position that the sale of vaporisers is prohibited in WA.[179]

United States of America

In 2008, the Food and Drug Administration (FDA) attempted to prohibit the importation of vaporisers by classifying them as medical devices under the *Food, Drug and Cosmetic Act 1938*. This would have meant that vaporisers would have been required to undergo medical trials. Following a successful court challenge from e-cigarette distributors in 2010, however, it was determined that vaporisers should be regulated as a tobacco product.[180]

Accordingly, in the United States of America only those vaporisers that are marketed for therapeutic purposes are currently regulated by the FDA Center for Drug Evaluation and Research.

The FDA has, however, proposed new rules that would extend its tobacco authority to cover additional tobacco products, including vaporisers. The new rules would mean that manufacturers of vaporisers would be required to:

- register with the FDA and report product and ingredient listings
- only market new products after FDA review
- only make direct and implied claims of reduced risk if the FDA confirms that scientific evidence supports the claim and that marketing the product will benefit public health as a whole
- not distribute free samples.

In addition, the rule would provide for:

- minimum age and identification restrictions to prevent sales to underage youths
- requirements to include health warnings
- prohibition of vending machine sales, unless in a facility that never admits youths.

Products that are marketed for therapeutic purposes will continue to be regulated as medical products.[181]

Until the proposed rules take effect, each State is responsible for the regulating the use of vaporisers.

178 Explanatory Notes, p.22

179 Department of Health (WA), *Fine sends warning on e-cigarettes sales*

180 A Sorrel, 'Judge: e-cigarettes not subject to FDA oversight as drug delivery device', *American Medical News*, 15 February 2010, accessed 2 October 2014, http://www.amednews.com/article/20100215/government/302159953/1/

181 U.S. Food and Drug Administration, FDA proposes to extend its tobacco authority to additional tobacco products, including e-cigarettes, *FDA News Release*, 24 April 2014, accessed 2 October 2014, http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm394667.htm

European Union

The European Union recently amended its Tobacco Products Directive which covers vaporisers. The Directive does not, however, apply to products that do not contain nicotine or medicinal electronic cigarettes (i.e. electronic cigarettes that have been licensed as a medicinal product after meeting medicinal purity and delivery standards and being proven to be an effective smoking substitute or cessation aid).

The Directive stipulates that:

- there must be a maximum concentration level for vaporisers and maximum volumes for cartridges, tanks and refill containers of nicotine liquid
- vaporisers and refill containers must be child and tamper proof – protected against breakage and leakage and have a mechanism for refilling without leakage
- high purity ingredients are to be used in nicotine-containing liquid and vaporisers must deliver nicotine at consistent levels under normal conditions of use
- vaporiser packs must display health warnings mandatory and include instructions for their use, information on addictiveness and toxicity, a list of all substances contained in product and information on nicotine content. No promotional elements allowed on packs.
- authorities must monitor the market for any evidence that vaporisers lead to nicotine addiction or to traditional tobacco consumption, especially in young people and non-smokers
- manufacturers must notify authorities before placing new products on the market – notification to include information on manufacturer, ingredients, nicotine dose and uptake, product and production process and declaration that manufacturer takes full responsibility for quality and safety of product under normal use.
- manufacturers must report annually to authorities on sales volumes of products, types of users and their preferences and trends
- manufacturers must comply with the advertising rules which currently apply to tobacco products.[182]

Member States have until 20 May 2016 to implement the Directive into their national legislation.

The Directive does not make provision for whether vaporisers may be used in smoke-free designated places. It is for each Member State to decide. In the United Kingdom, for example, the use of vaporisers is permitted in designated smoke-free places.

United Kingdom

In the United Kingdom, the use, sale and advertising of vaporisers is currently legal and they are not regulated under smoke-free laws.

Vaporisers are currently regulated as general consumer products. Once the EU Tobacco Products Directive comes into effect in Member States, such as the United Kingdom, vaporisers containing up to 20 mg/ml of nicotine will come under the Directive.

Vaporisers and products containing 20 mg/ml of nicotine and above, or if manufacturers and importers decide to opt into medicines regulations, will require authorisation by the Medicines and Healthcare Products Regulatory Agency as over the counter medicines in the same way as NRT, such as nicotine patches and gum.[183]

The United Kingdom has also announced that it will prohibit the purchase of vaporisers by persons under the age of 18 by 20 May 2016.

182 Directive 2014/40/EU of the European Parliament and of the Council of 3 April 2014 on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco and related products and repealing Directive 2001/37/EC, 2014, OJ L127/1

183 Action on Smoking and Health (UK), *Electronic cigarettes*, ASH briefing, June 2014, http://www.ash.org.uk/files/documents/ASH_715.pdf

New Zealand

Medsafe (the body responsible for the regulation of medicines and medical devices in New Zealand) has not approved any vaporisers for sale in New Zealand.

It is, therefore, illegal to sell a vaporiser in New Zealand that contains nicotine. It is also illegal to sell a vaporiser (with or without nicotine) that claims to help smokers quit, or a vaporiser that looks like a tobacco product (or smoker's pipe) to a person under 18 years old.[184]

184 Ministry of Health (New Zealand), *Electronic Nicotine Delivery Systems (ENDS), including E-cigarettes*, 2 October 2014, http://www.health.govt.nz/our-work/preventative-health-wellness/tobacco-control/electronic-nicotine-delivery-systems-ends-including-e-cigarettes