TRANSCRIPT OF PROCEEDINGS

THE MEDICO-LEGAL SOCIETY OF VICTORA

in association with

THE AUSTRALIAN ACADEMY OF FORENSIC SCIENCES

VIRTUAL MEETING
MELBOURNE

TUESDAY 25 AUGUST 2020

WEBINAR PRESENTATION

On the topic of:
'LIVING WITH COVID-19: THE NEW NORMAL'

APPEARANCES:

MR W. EDWARDS (President MLSV)

THE HONOURABLE JUSTICE CHAMPION SC (Chair of the Victorian Chapter of the AAFS)

DR A. GROSSI (Presentation Chair)

PROFESSOR S. KENT

PROFESSOR B. SUTTON

PROFESSOR F. GERRY QC

Epiq Australia Pty Ltd
4/190 Queen Street Melbourne

Telephone: 8628 5555
Facsimile: 9642 5185

1 MR EDWARDS: Well, I think time to start. Well, welcome.
2 Welcome to the first internet-based meeting of the
3 Medico-Legal Society of Victoria. This meeting is a first
4 from another viewpoint. It's our first combined meeting,
5 this with the Victorian chapter of the Australian Academy
6 of Forensic Sciences. Being a first, I have to ask for
7 forbearance. We are dealing with, to us, unfamiliar
8 technologies and trying to get them to work.
9 The meeting's borne out of the frustration of being
10 forced to cancel a carefully crafted program for this
11 year. To explain to those unfamiliar with the
12 Medico-Legal Society of Victoria, we are a learned
13 society, established to foster knowledge and collegiate
14 interaction between our two professions.
15 We have run meetings since 1931, mostly over dinner,
16 probably four or six times a year, with a speech on a
17 topic of interest to provoke thought and generate
18 discussion, this in a convivial atmosphere. We are about
19 learning, fellowship, and fun. Today, our interaction is
20 probably going to be a bit stilted, but I trust that the
21 ideas of interest will abound.
22 Here's John Champion to speak on behalf of the
23 Australian Academy of Forensic Sciences. John.
24 CHAMPION J: Thanks, Will. Well, good evening everybody. My
25 name is John Champion. I'm the chair of the Victorian
26 chapter of the Academy of Forensic Sciences. On behalf of
27 our executive committee, I welcome you all to the webinar
28 this evening. I especially welcome members of the
29 Victorian chapter and those attending from the national
30 body in New South Wales, as well as the ACT chapter, and
31 I warmly welcome those who I know are attending from

1 England, from the Netherlands, and from New Zealand. And
2 we are delighted to co-host this webinar with the
3 Medico-Legal Society.
4 Now, I'd like to begin by acknowledging and paying
5 my respects to the Traditional Custodians of the land upon
6 which each of us is located. I pay my respects to their
7 Elders, past and present, and acknowledge all Aboriginal
8 and Torres Strait Islanders present this evening. Also
9 paying my respects to your Elders past and present.
10 Like Will, I want to say a few words about our
11 Academy, but just again ask for your forbearance to go
12 into a little detail. The Australian Academy of Forensic
13 Sciences was founded in 1967, and is the learned body.
14 It publishes a regular journal of high quality. The
15 Academy has chapters in three states, and provides
16 opportunities for leaders in forensic science, law and
17 medicine to meet, discuss, and exchange news about many
18 issues concerning these three disciplines.
19 To give you some idea of how and where we focus our
20 attention, in Victoria we hold four plenary sessions each
21 year and an AGM. The plenary sessions involve highly
22 qualified presenters relevant to the three areas that I've
23 mentioned. Our executive committee comprises senior
24 leaders from these areas. Following the wrongful
25 convictions of two Victorian men, Farah Jama and Tomas
26 Klamo, across 2012 and 2013, the Victorian chapter of the
27 Academy was revitalised from its previous dormancy.
28 For those that don't recall, Jama involved a case
29 where a DNA sample had been compromised, which went
30 unrecognised at trial, and Klamo was a case concerning the
31 death of an infant alleged to have been caused through

1 shaking. In both cases, the convictions against these men
2 and resultant sentences of imprisonment were overturned
3 substantially on the bases that included that the expert
4 evidence presented in the cases did not support the
5 findings of guilt that had been adduced at their trials.
6 Now, these are very brief and imperfect
7 descriptions, but serve the purpose of informing you why
8 the Victorian chapter began its work again, and it did so
9 at the instigation of people such as Chris Maxwell,
10 President of the Victorian Court of Appeal; Stephen
11 Cordner, the then director of the Victorian Institute of
12 Forensic Medicine; and Frank Vincent, now retired justice
13 of our Court of Appeal. Frank's image came up briefly a
14 moment ago as I was speaking, and I make reference to his
15 presence, and we're very grateful for him to be present
16 tonight.
17 I'll touch briefly on an event that occurred last
18 year as an example of where our journey has taken us so
19 far, and where we look forward to going. In November last
20 year, the Victorian chapter held a two-evening summit in
21 our Supreme Court building, which examined important
22 issues relating to the assessment of the validity and the
23 reliability of expert evidence in criminal trials. The
24 summit was opened by the Victorian Attorney-General, the
25 honourable Jill Hennessy. Papers that were presented by
26 eminent people in the appeals and an editorial describing
27 the outcome of the summit have been published in the June
28 2020 edition of our journal.
29 Following the summit and following on from our
30 papers previously written - from papers previously written
31 by Chris Maxwell and views publicly expressed by our

1 Attorney, the Council of Australian Attorneys-General
2 announced a national review of forensic medicine - of
3 forensic science, I apologise. We were very pleased to
4 have made a contribution to that outcome, which in turn we
5 hope will ultimately contribute to the highest quality of
6 forensic evidence being used in criminal trials and the
7 reduction of miscarriages of justice.
8 As to the webinar this evening, our chapter is very
9 pleased to co-host this webinar with the Medio-Legal
10 Society. As has been said, it's the first time. The
11 topic is important and timely for us all. I express my
12 thanks to all of those who have put the time and effort
13 into organising it, and to our speakers who have given
14 their time to contribute. Thank you very much, and I'll
15 now hand back to Will Edwards to take us to the next phase
16 of our meeting this evening.
17 MR EDWARDS: Well, thank you John. Before we start, to
18 optimise the presentation, I'm just reminding you, please
19 set your video and audio to off. Select gallery view.
20 Pass your cursor over a no-video participant. Touch the
21 blue button and push hide. This will give you four
22 speakers on your computer screen. If that doesn't work,
23 switch to speaker view, and you'll see one speaker at a
24 time, but the person speaking. We can take questions over
25 the chat function of Zoom. Over to Antonio.
26 DR GROSSI: Thank you William and John, and good evening ladies
27 and gentlemen, members of the Medio-Legal Society of
28 Victoria, and members of the Australian Academy of
29 Forensic Sciences and guests. My name is Antonio Grossi,
30 I'm an anaesthetist and a committee member of the
31 Medio-Legal Society of Victoria, and it's my privilege

1 today to share some (indistinct words) where the new
2 normal is with COVID. I also would like to acknowledge
3 the Traditional Custodians of this Country and pay tribute
4 to the Aboriginal leaders past, present and emerging. May
5 their ancestors and your ancestors watch out over you
6 during these challenging times.
7 People, we are in the midst of a pandemic caused by
8 a bitter coronavirus that originated in Wuhan, China and
9 has spread throughout the world causing a respiratory and
10 inflammatory known as COVID-19. As we speak, about 23.4
11 million people have been infected, and over 809,000 souls
12 have been lost, and many more lives and livelihoods
13 continue to remain significantly threatened. This
14 pandemic has disrupted the way we travel, work,
15 communicate, and interact at all levels.
16 Earlier this year, many had hoped that we would just
17 get through this and get back to normal soon enough, but
18 the reality that we may never return to a normal before
19 coronavirus is becoming more and more apparent, and it's
20 time now to contemplate the new normal, the new normal
21 after coronavirus. And I'm very privileged to have three
22 expert and eminent spears to help me in this discussion
23 tonight: Professor Stephen Kent, Professor Brett Sutton,
24 and Professor Felicity Gerry.
25 Professor Stephen Kent is an infectious diseases
26 physician at the Alfred Hospital, and a professor of
27 microbiology and immunology at the University of
28 Melbourne. He leads a talented team of scientists at the
29 Peter Doherty Institute that have been studying the
30 immunity to COVID-19 in people who have covered from the
31 infection, that have been developing monoclonal antibody

1 therapies for COVID-19 and have been studying
2 vaccine-induced immunity in animal models. Overall,
3 Stephen keeps his head down (indistinct words) important
4 research and avoids the media.
5 The next speaker, Professor Brett Sutton, is known
6 to all of you. Thanks, Brett, for all the hard work
7 you've bene doing. He is Victoria's Chief Health Officer,
8 and as the Chief Health Officer undertakes a variety of
9 statutory functions under health and food hygiene
10 legislation. He also provides expert clinical and
11 scientific advice, and leadership on issues impacting on
12 public health. He is the spokesperson for the Victorian
13 Government on matters relating to health protection,
14 including public health incidents and emergencies.
15 Professor Sutton has extensive experience and
16 clinical expertise in public health and communicable
17 diseases gained through emergency medicine and field-based
18 international work, including Afghanistan and Timor-Leste.
19 He represents Victoria on a number of key national bodies,
20 including the Australian Health Protection Principal
21 Committee. He is also Chief Human Biosecurity Officer for
22 Victoria. Professor Sutton has a keen interest in
23 tropical medicine and incorporation of palliative care
24 practice into humanitarian responses.
25 Professor Sutton is a fellow of the Royal Society of
26 Public Health and a fellow of the Australasian College of
27 Tropical Medicine, and fellow of the Australasian Faculty
28 of Public Health Medicine. He is also a member of the
29 Faculty of Travel Medicine. Welcome.
30 Professor Felicity Gerry QC is a professor of legal
31 practice at Deakin University, Melbourne, where she

1 lectures in contemporary international legal challenges,
2 including modern slavery, terrorism, war crimes and
3 climate change law. She has experience in Australia
4 biosecurity law and co-authored the quick reference guide
5 to the Federal and Victorian COVID-19 emergency law with
6 one of her readers.
7 As Queen Counsel, she sits on the list of counsel at
8 the International Criminal Court and the Kosovo Specialist
9 Chambers in The Hague. She is admitted to the Bar in
10 England and Wales (indistinct words) long history of law
11 and policy experience on a range of topics relating to
12 human rights, criminal justice, penal reform, including
13 policy submissions and taking appeals on human rights
14 issues. These have been on behalf of a range of people
15 including pregnant offenders, trafficked women, and those
16 convicted of serious crimes such as murder.
17 She has led applications to the European Court of
18 Human Rights in context of criminal laws affecting those
19 with autism, HIV, and where over-criminalisation and
20 over-incarceration dominates against - discriminates
21 against Black and ethnic minority groups. She also
22 maintains an administrative law practice in these
23 contexts.
24 So to get the ball rolling, I'm going to ask our
25 speakers a few questions, and we will take comments and
26 explore these topics and take us where they will. But
27 firstly, I'd like to get the ball rolling by asking you a
28 question, Professor Kent, on - a bit on the virology and
29 immunology and vaccinology of COVID. When this all began,
30 many hoped we could eliminate the virus, this nasty little
31 parasite that's caused so much damage. It's not even

1 really a living thing, is it, until it infects our body.
2 But viruses are ubiquitous, they're diverse, and
3 they're very powerful, and they play an important role in
4 nature and evolution, so living without viruses is
5 actually unrealistic. It seems in some way, we must learn
6 to live with COVID-19. So can you tell us a little but
7 about the virology, Stephen, and how it gets into our
8 bodies, and what the reaction it triggers looks like, and
9 how is this pertinent to developing an effective vaccine?
10 PROFESSOR KENT: Yes, sure. Thanks, Antonio, and welcome
11 everyone. So yes, my laboratory was happily studying HIV
12 and influence and other viruses up until February this
13 year, and we saw this virus sweeping the globe, and really
14 I guess have just completely refocused on applying some of
15 the things - the technologies and things that we've learnt
16 about other viruses onto this coronavirus.
17 So one of the first things we did as people were
18 starting to get infected in Victoria was recruit a cohort
19 of around about - it's about 100 people who've recovered
20 from COVID-19 and really studied what immune response they
21 had, and we were really kind of pretty pleasantly
22 surprised how robust those responses were, and most people
23 who recovered from COVID-19 developed antibodies that can
24 neutralise the virus, and we know from other viruses that
25 they're usually pretty helpful in preventing infection.
26 We tried to understand the things that helped people
27 make those antibodies, and we understand there are certain
28 parts of our cellular immune system that do that. So
29 we're pretty, I guess, bullish on the early immune
30 response to COVID. We think that's pretty robust, we
31 think it's probably - I should sort of preface this by

1 saying I'm going to speculate from time to time in the
2 interest of generating discussion. Please don't hold me
3 to this - any of this when it all proves to be wrong in
4 six months' time.
5 We've more recently been studying the decay in that
6 immunity out to about four months. So in Victoria we had
7 a big wave in March, and we recruited a bunch of those
8 people, and we've just recently rebled them. And again,
9 we've been largely encouraged by how durable the immunity
10 is in people that have recovered from COVID-19. There are
11 some people's antibodies will decline to very low levels.
12 There are starting to be reports of reinfection with this
13 virus, just very early days.
14 But again, we've actually been really pleasantly
15 surprised by how robust types of cellular immunity, both
16 B-cells and T-cells are against this virus, and we think
17 that reinfections will almost certainly be pretty mild,
18 and hopefully less transmissible. So that's, I think,
19 good news for people who've gotten over the virus and
20 haven't succumbed to it, so I think that's good news.
21 One of the things that we've done with the people
22 that have recovered from virus is pull out particular
23 antibodies called monoclonal antibodies that we can use as
24 a treatment. And curiously, people who have the worst
25 infections have the best neutralising antibodies, and
26 we're part of a large consortium in Victoria that are
27 developing these monoclonal antibodies as a treatment, and
28 I'm pretty bullish about these as a treatment. I think
29 they'll work. I don't think they're going to be the
30 cheapest or easiest thing in the world, but I'm a little
31 bit more bullish about them compared to repurposing drugs.

1 We've all seen the terrible waste of time and effort
2 on Hydroxychloroquine, and some of the other treatments
3 are generally on the modest side of effective. There's no
4 disrespect to our colleagues in intensive care and so on
5 that are doing an incredible job of saving lives, but we
6 really don't have much in the way of our - of treatments
7 right now.
8 And then just lastly, we've been using some of our
9 knowledge about vaccines for other viruses to study
10 coronavirus vaccines in animal models, not so much because
11 we want to be the person that develops the vaccine, but
12 really to understand immunity. And again we've been
13 really pleasantly surprised how easy it is to induce
14 neutralising antibodies in animal models using very basic
15 vaccine technologies, and for that reason I'm very bullish
16 on us getting a vaccine that will work, and I think
17 there's some major issues around production, distribution,
18 equity. It's going to be a complete bunfight, and I don't
19 know, I'll stay right out of it.
20 But I think a vaccine will work. How durable
21 immunity will be to vaccinations and all the different
22 ones that are coming around from the groups around the
23 world I think is going to be a big issue, booster
24 vaccinations and so on. There's just so many unknowns,
25 but I think we'll get there, Antonio.
26 DR GROSSI: That's great.
27 PROFESSOR KENT: I don't think it'll go back to normal, but I'm
28 pretty positive about it in general.
29 DR GROSSI: Well, that's great. That's a very positive answer
30 and a very hopeful answer to start of the discussion, so
31 thank you. Just a quick follow-up question. What do you

1 think in your opinion then if people use drugs like
2 Dexamethasone or other interleukin blockers as part of a
3 treatment? Do you think that will diminish the long-term
4 immunity in those patients potentially?
5 PROFESSOR KENT: No. Look, Antonio, those drugs are typically
6 used in very severe cases. Those people, when they - if
7 and when they recover make the most amazing immune
8 responses.
9 DR GROSSI: Okay.
10 PROFESSOR KENT: So they're good to go. They're immune if they
11 make it through.
12 DR GROSSI: All right, thank you. My next question is for
13 Professor Sutton. As I said earlier, thank you for all
14 the hard work that you guys are doing in keeping us
15 informed about things. The Government obviously had to
16 act and mitigate the risk of this pandemic. Can you give
17 us some (indistinct words) on where we are now
18 (indistinct) until Christmas, and how do you envisage our
19 road to recovery will look like?
20 PROFESSOR SUTTON: Thanks, Antonio, and thanks so much to the
21 Victorian chapter of the Australian Academy of Forensic
22 Sciences and the Medio-Legal Society of Victoria for
23 hosting. It's great to be here. You broke up a little
24 bit on that question, but I think you were asking me where
25 are we at now, and where are we headed. Is that your
26 summary?
27 DR GROSSI: Yes.
28 PROFESSOR SUTTON: Yes. Look, I think clearly we're in the
29 second wave. We're past our peak for our second peak.
30 I'm very confident of that. Obviously we saw some days of
31 over 700 cases, new cases per day. We're now below 150

1 for the last couple of days, and clearly the trajectory is
2 looking good. We're coming down by reasonable increments
3 every day, and the seven-day trend is good in that
4 respect.
5 We're headed to, you know, low numbers, below 50 and
6 maybe better by September 13, although the tail of any
7 epidemic curve gets pretty complex. The cases that you're
8 left with are your trickiest cases, and as we know, it
9 only takes a single case in a particular setting in
10 particular circumstances that can amplify the
11 transmission, you know, to be in a super spreading
12 setting, let alone being a super spreader as an
13 individual, so there's that combination of how infectious
14 someone is, but also the setting that they're in as to how
15 much transmission occurs.
16 But overall, I think we're clearly heading down our
17 effective reproduction number, or the average number of
18 people infected by one infectious individual is - I saw
19 today .81, so out of 100 infected people, 81 on average
20 were infected in a generation of transmission, five or
21 six days, so that's positive. I actually think it's
22 probably lower than that. That's a calculation based on
23 the numbers that we're seeing now, which actually relates
24 to transmission that occurred some days earlier, and we've
25 had an improvement in terms of the restrictions being in
26 place.
27 So we're going in the right direction. We're
28 certainly looking to meet the national overarching
29 strategic objective of no community transmission, so
30 called aggressive suppression. Others might call it
31 elimination, but not calling it elimination is really just

1 a recognition that the virus is all around is. It's in
2 every other - almost every other country of the world.
3 It'll always be potentially coming to our shores, maritime
4 crew, in international arrivals, or through other
5 mechanisms. But getting to know community transmission is
6 an aim, and it means that we can control that state by
7 lifting restrictions and not being concerned about a
8 really significant resurgence.
9 If we're left with very low levels of transmission,
10 then we want to be in a position whereby we can manage
11 each and every one of those cases with a robust public
12 health response, a very timely identification of cases
13 through promoting testing, making sure people get those
14 tests turned around in a very quick period of time, and
15 then to have those cases called by our public health
16 officers and their close contacts identified and
17 quarantined.
18 They're the pillars of the public health response.
19 We can manage that if we have very, very low levels. But
20 it would be even more reassuring to get to zero
21 transmission whereby we know that we can lift even more
22 substantially as long as we keep a very, very close eye on
23 broad surveillance, sewage surveillance, case surveillance
24 across the entire State, and with some assurance that
25 every other jurisdiction in Australia is in the same
26 position so that we don't have to worry about those
27 incursions across our internal boarders because we know
28 that's been an issue in Australia.
29 So I'm hopeful. Also to end on a hopeful note,
30 we're clearly going in the right direction, but that tail
31 of the epidemic is really tricky. We'll end up with

1 settings that have complex transmission chains. This
2 virus exploits any gap, socioeconomic, workforce mobility,
3 casualised labour, vulnerable marginalised population
4 groups, hard to reach - so-called hard to reach groups.
5 If we don't identify those gaps and try and address them
6 in the fullest possible way that we can, then we'll see
7 the virus re-emerge in those areas.
8 DR GROSSI: Thank you very much for that comprehensive answer.
9 I suppose looking at what happened in New Zealand and some
10 of the other States, elimination probably is not a
11 possibility per se, but if we learn to live with it and
12 learn to change our behaviours in some ways, at least we
13 can manage small outbreaks with appropriate contact
14 tracing as you've described, so that's quite hopeful.
15 Professor Gerry, may I ask you a question now?
16 Obviously the Government had to - the outbreak of COVID-19
17 required a quick and decisive and effective action to be
18 taken by all Australian Governments. But there's often a
19 balance, isn't there, between mitigating risk and
20 unnecessarily impinging on people's human rights. Can you
21 talk a little bit about your view on the restrictions
22 implemented in terms of community consultation,
23 proportionality, transparency, duration, and the overall
24 impact on life and health?
25 PROFESSOR GERRY: Yes. I'll try and fit all that into a
26 reasonably short response. Thank you to the Australian
27 Academy for Forensic Science and the Medico-Legal Society
28 for having me. I think the headlines are that normally we
29 have a semblance of freedom, and the current normal lacks
30 that sense of freedom.
31 And from a medico-legal perspective, what that can

1 mean is that our freedoms include rights to make mistakes,
2 rights to self-harm, and rights to suicide. It's terrible
3 to think about those terrible health consequences, but
4 freedom actually means the right to take a risk in many,
5 many circumstances. Getting in a car is the classic
6 example.
7 So when we talk about rights and freedoms, it sort
8 of includes our rights and freedoms to do some terrible
9 things. But when that has a community effect, then we
10 have a public health response, and I think it's really
11 quite important to recognise that in the context of a
12 global pandemic, there was a need to have a public health
13 response. So speaking as a human rights lawyer, I'm not
14 suggesting for a moment that there wasn't a need for a
15 public health response.
16 And then you have to go and think about, well, you
17 know, what are these rights? It's not really labelled a
18 right to mistake, self-harm, or - in that sense. But what
19 is the right to health? And there's really quite a lot of
20 learning about what the right to health is, and trying to
21 keep it simple, we have a right to the highest attainable
22 standards of health, and that right is what we call as
23 lawyers non-derogable. You can't just say, 'Oh, well,
24 there's a pandemic so you haven't got a right to health
25 anymore', or, 'Brett's got a right to health and I
26 haven't'.
27 It isn't a balancing exercise. You have the highest
28 - the right to the highest attainable standards of health,
29 firstly to be - to not be infected with COVID-19. We have
30 to have public health response to do our best to make sure
31 that people are not infected with COVID-19 as a public

1 health response. But also we then have a necessity for
2 positive steps to make sure that the responses we have to
3 COVID-19 don't affect people's rights to health.
4 So the right to health is really interesting. In my
5 view, it's intrinsic to the right to life. If you don't
6 have good health, your life is expectancy is probably
7 shortened. So that gives us a window into how tough the
8 decision making is for a government. Where there's a
9 necessity for a public health response, you have to have a
10 response that maintains those rights to the highest
11 attainable standards of health across the board, whether
12 you're combatting COVID-19, or in the response you - that
13 you make to COVID-19.
14 So I've rather enjoyed trying to explain this to
15 people on a regular basis. And then, of course, you have
16 other rights, and the decisions that are taken in relation
17 to how we combat COVID-19, and what directions are made,
18 and what powers - very, very coercive powers are used.
19 They can impact on other rights, and the areas that I'm
20 particularly interested I without giving you all the human
21 rights are policing, so our freedom of movement, prisons,
22 duty of care towards people's health, protests, our rights
23 to assembly. Frankly at the moment in lockdown in
24 Victoria, our right to just go outside.
25 So you can start to see how the decisions that are
26 made at a government level can affect not just our rights
27 to health, but also all our others rights are limits -
28 limited. And there are limits to those limits. There
29 comes a point when the decisions made can be
30 disproportionate. But although there's a risk, there are
31 - there comes a point when the impact of all those

1 decisions is so significant that it's no longer necessary,
2 or it's disproportionate. It may not be reasonable.
3 There are all sorts of legal tests that I won't bore you
4 too much with at the moment.
5 And this is where questions of proportionality and
6 accountability come in. The other thing I've really
7 enjoyed doing in Victoria over the last few months is
8 saying, well, there are actually human rights in
9 Australia. And there's this sort of mantra we don't have
10 a bill of rights, and frankly we should of course across
11 the whole of Australia, but there's a charter that has
12 required some human rights compliance.
13 But really interestingly, human rights principles
14 are actually contained within the Public Health and
15 Wellbeing Act. So when Parliament voted to have a Public
16 Health and Wellbeing Act, and created the framework for
17 these emergency powers, Parliament said in s.8 - this is
18 as legal as I'm going to get, but in s.8 is the principle
19 of accountability, which reads as follows, and it's worth
20 hearing. It's short.
21 'Persons who are engaged in the administration of
22 this Act should, as far as is practicable, ensure that
23 decisions are transparent, systemic and appropriate'. And
24 then it goes on, 'Members of the public should therefore
25 be given access to reliable information in appropriate
26 forms to facilitate a good understanding of public health
27 issues, and opportunities to participate in policy and
28 program development'.
29 Now, how unusual is that? You can do a survey of
30 laws that doesn't - that don't say we've got to have
31 community involvement. And herein lies the basic problem

1 that I see, is that obviously there was a scramble to work
2 out how this was going to be done. I'm not going to
3 criticise anyone for that. There's been some really great
4 work done, and thank you Brett of course for the work that
5 you've done.
6 But what we tend to see is government, police and
7 health, and we don't see community at the same high level.
8 There are some examples, but this opportunity to
9 participate in policy and program development, upfront
10 strategic planning involving community voice is less
11 visible. Transparency, systemic and appropriate,
12 reviewing things after the event, not really great.
13 The example I tend to use is in England and Wales,
14 there was a review of all policing under certain pieces of
15 legislation, and under one piece of coronavirus
16 legislation, 100 per cent of the charges were unlawful,
17 and we haven't seen that type of review, so there's a real
18 risk of criminalising the community.
19 And then very quickly, s.9 of the same piece of
20 legislation gives us the principle of proportionality. So
21 again, human rights principles contained in the very
22 legislation that's being used to control our conduct, and
23 that reads, it's only four lines, 'Decisions made and
24 actions taken in the administration of this Act should be
25 proportionate to the public health risk sought to be
26 prevented, minimised, and controlled, and should not be
27 made or taken in an arbitrary manner'.
28 So in those two sections, we've got all the burden
29 that sits on Brett, Government, in making the advices and
30 decisions, and in relation to the actions taken. So from
31 a criminal human rights lawyer perspective, it's got

1 everything in it for holding governments accountable, but
2 more importantly by community decision making in what's
3 going to happen next.
4 DR GROSSI: Thanks, Professor Gerry. That was a very
5 comprehensive answer to a big question, so thank you very
6 much. There's a lot to unpack there, but I suppose when
7 the crisis first hit, the Government needed a nimble team
8 that could respond quickly to try and get control of
9 things. But perhaps going forward now, if we look to what
10 the new normal is going to look like, we might look to see
11 what else can be improved upon in terms of engagement with
12 community and other consultations.
13 Professor Sutton, is there any comments you'd like
14 to make based on what's been said at this point?
15 PROFESSOR GERRY: Can't hear him.
16 DR GROSSI: Sorry, we couldn't hear you there. Try again.
17 PROFESSOR GERRY: Somebody's got to unmute him. I think it's
18 me that's still on volume, and someone needs to unmute
19 Brett.
20 DR GROSSI: Have we lost Brett?
21 PROFESSOR SUTTON: Here I am.
22 DR GROSSI: There he is. You're on, yes, go.
23 PROFESSOR SUTTON: Yes, I'm trying to unmute.
24 DR GROSSI: You're muted again.
25 PROFESSOR SUTTON: Host is muting me.
26 DR GROSSI: You just leave it. Yes, just leave it.
27 PROFESSOR SUTTON: Done.
28 DR GROSSI: We can hear you now.
29 PROFESSOR SUTTON: All right. Sorry about that. Look, I'm
30 absolutely mindful of that. The Public Health and
31 Wellbeing Act is the Act that enables me to have all of

1 the powers to issue the public health directions that are
2 part of our constrained activities in our lives and have
3 been for some time, so the issues of being evidence-based,
4 being reasonable, being proportionate and accountable are
5 absolutely front of mind.
6 I have reflected on the fact that there are
7 impossible choices in this. You are balancing harms in
8 many respects, and so it's also been through a phase where
9 evidence is not manifestly clear. There's emergent
10 evidence. There are issues that arise that change your
11 view about how you need to act, and there are certainly
12 lessons about countries that have acted just that little
13 bit too late that have had absolutely catastrophic
14 consequences, and so there is an element of needing to
15 make agile decisions with - and the emergency management
16 rule talks about the 70 per cent rule. You can never wait
17 to have enough information to be absolutely sure about the
18 actions that you need to take, because if you wait that
19 long, this virus will already be ahead of you.
20 So it is a very tricky balancing act, but no
21 question that I'm mindful of those obligations. I do
22 think that it's always - we need to continue with our
23 efforts with community engagement, because we can go to
24 umbrella groups and other representative bodies,
25 stakeholders and through cabinet with their ministers and
26 the secretaries of departments, but getting down to an
27 appropriate level where we have a genuine understanding of
28 how the man and woman on the street are affected by this,
29 and how they view these decisions is a really critical
30 issue as well.
31 DR GROSSI: Thank you. Professor Kent, can I ask you about

1 herd immunity, and you touched on a few of the issues
2 earlier. It seems as though until we get a decent herd
3 immunity, we're never really going to be able to get out
4 of this completely. What's your view of that with COVID,
5 and are we only going to get there with a vaccine, or will
6 we ever get there?
7 PROFESSOR KENT: Yes. I think herd immunity is a good term for
8 cattle, and not a very good term for people. I don't know
9 if people saw, there was a report where a boat left
10 Seattle with 120 people on board, and came back with
11 100 infections. And amongst the 20 people that didn't
12 catch the virus were three that had already caught it,
13 which is actually pretty good - pretty good for a vaccine.
14 But yes. I am very not bullish about herd immunity.
15 I think it should never have come up, and I just think
16 that way more than 60, 70 per cent of people are going to
17 be susceptible to this virus, and you know, that's not a
18 herd. That's a population.
19 DR GROSSI: Yes. Okay, thank you. Well, that means we're in
20 it for the long haul, and someone once said that
21 pestilence requires endurance. Professor Gerry, would you
22 make some further comments about the implementation
23 (indistinct) of the policies, and people suffering from
24 lockdown fatigue, and potentially being non-compliant. Do
25 you think this is a problem that could play out if we're
26 in it for the long haul? Professor Gerry? You just have
27 to unmute your mic. You've got it.
28 PROFESSOR GERRY: Yes. I think you should be able to hear me
29 now.
30 DR GROSSI: Yes, we can.
31 PROFESSOR GERRY: So I mentioned this a little bit earlier on,

1 this idea that there are limits to proportionality, there
2 are limits to the restrictions on our rights to associate,
3 assemble, and so forth. There are also significant
4 effects on particular parts of the community, so very
5 vulnerable people are more significantly affected
6 sometimes by the responses.
7 So the example that I usually give are the public
8 housing in Victoria, the idea that 500 police officers
9 turn up outside your door, and is the equivalent of
10 detention, is a really shocking experience. And you can
11 have every doctor you like with a lovely bedside manner,
12 but the practical reality is that you're frightened to go
13 out of your house, and there can be real fear amongst a
14 community about going out, about meeting, about X rights
15 to education, about other areas in which you want to
16 associate with your family, your right to family life.
17 So, look, I don't like the language of compliance.
18 I think what we're doing - as best we can, we're asking
19 people to voluntarily engage in understanding what's
20 necessary, and at times we have some very draconian
21 directions, and they have to be limited. You cannot lock
22 people up effectively in their houses forever, and it is a
23 very, very difficult decision to make. That much I
24 accept.
25 But when you look at the most vulnerable members of
26 our community, in public housing, in prisons, women at
27 risk of domestic violence, human trafficking victims who
28 are not necessarily identified in criminal justice
29 processes, all those people that we as lawyers think
30 about, but they're not necessarily thought about by the
31 general public, you can start to see levels of harm that

1 can occur to significant swathes of society.
2 In terms of numbers, the data, those sorts of areas
3 are pretty high too. So, you know, you can start to talk
4 about large proportions of the population who are already
5 vulnerable, and have increased vulnerability as a result
6 of what's currently going on. So whilst it is a really
7 difficult decision to take for a government to bring a
8 community out of the sort of level of lockdown that we've
9 got at the moment, it is a decision that has to be taken,
10 and ultimately one has to take it in a way that enables
11 people to emerge to a new normal that is not community
12 detention.
13 It's a new normal that involves respect and
14 understanding and the dignity of human rights, that in
15 emerging you do need to respect the human rights of your
16 fellow members of the community, and we've seen that in
17 the sense that we came out and we went back in again. But
18 the idea is if you come out and don't behave yourselves,
19 you're going back in again, is still extraordinarily
20 coercive.
21 This is probably not the only virus that we're going
22 to have to deal with from time to time as populations
23 grow. There are all sorts of issues around mass
24 displacement and climate change, serious issues that are
25 going to affect people's health. So this pandemic is a
26 position where we can strategically plan for other serious
27 events, but that does include planning to come out of
28 lockdown, because it harms the community, it removes
29 community freedoms.
30 DR GROSSI: Okay.
31 PROFESSOR GERRY: And that is the only approach you can take as

1 a human rights lawyer, recognising the risk of harm that
2 there is from the virus.
3 DR GROSSI: Professor Sutton, how do you see us emerging then,
4 and do you think that there's some differences,
5 demographic differences, in the different cohorts of ages
6 too in the response of the 20 to 30 year olds versus the,
7 say, elderly and those who have chronic disease?
8 PROFESSOR SUTTON: Yes, look, I think we absolutely have to
9 come out of this at the earliest possible time. So these
10 constraints shouldn't be on any longer than is necessary.
11 There is a precautionary principle that's also mentioned
12 in the Act, and so we don't want to come out of it with a
13 significant risk of a resurgence that would either have us
14 try and go through another lockdown if we think that's
15 proportionate, or let it run because there's no stopping
16 it if something as infectious as this virus carries on.
17 And I think these are the dilemmas that Europe are
18 going to go through now especially. It's not an island
19 state, and they don't have the option of closing off
20 freedom of movement across those country boarders in
21 Europe, and so they are literally coming to those
22 impossible choices in Italy and Spain that have already
23 seen 40-50,000 deaths, and have already had a longer and
24 in some respects a harsher lockdown than Victoria. In
25 Spain, children didn't leave homes for six weeks straight.
26 We've never had that. People couldn't exercise beyond 150
27 metres from their home.
28 So we absolutely have to be proportionate. It
29 shouldn't be in longer - it shouldn't be in place any
30 longer than it needs to be, but we do need to have an
31 assurance that we're not lifting too early and just

1 leading to more impossible choices.

2 In terms of different cohorts, we have to be mindful
3 of protecting the most vulnerable to severe disease. But,
4 you know, I've especially reflected on the fact that
5 protecting the most vulnerable, and that's the elderly,
6 those over 65 especially, happens by reducing the overall
7 transmission in society. You know, as much as you would
8 want to say, you know, we can shield the elderly, that was
9 an explicit policy in the UK, or to say we're going to
10 protect people in residential aged care facilities by
11 reducing visitors and screening for symptoms and doing
12 fever screening for staff, it's impossible to protect as
13 much as you'd like to.

14 We can't stop visiting our grandparents or great
15 grandparents or parents for months and months and months.
16 We can't stop people who are living in the community and
17 working in aged care facilities from being able to provide
18 that direct care. So I would say that protecting the most
19 vulnerable comes primarily in that hierarchy of controls
20 through reducing the risk overall, which is the general
21 transmission in society.

22 I think it's a little bit of an absurdity to say let
23 it run for those of us who want to engage with a mild
24 disease for us as 20 to 29 year olds, and just protect
25 those most at risk, because it effectively can't be done.
26 We don't live like that as society, and there's no
27 feasible practical way to shield people for months on end
28 from that level of human interaction.

29 DR GROSSI: Thank you. This question is for everybody.
30 Basically, just looking at the images that have emerged
31 from this pandemic across the world, there's empty streets

1 and empty buildings, even in Melbourne. It's almost a
2 spooky silence, melancholy. It's something apocalyptic.
3 How do you think this will play out going forward?
4 Working from home will probably be a lot more prevalent,
5 at least in part.
6 And so a lot of the social constructs and things
7 that we used to do will have to change. How do we
8 recalibrate? And just as a bushfire clears out the
9 undergrowth, do you think there will be a renaissance of
10 the human spirit that will allow us to come together and
11 deal with this? What's your vision of hope for the
12 future? Stephen?
13 PROFESSOR KENT: I guess I'm not the undergrowth of the
14 bushfire. Yes, I mean, I'm not an expert in this,
15 Antonio, but there is a new normal I guess and working,
16 exercising, travel is a massive one for many of us. So
17 (indistinct words). I think we've got some feedback or
18 something.
19 DR GROSSI: (Indistinct words) sorry about that.
20 PROFESSOR KENT: Yes, I'll finish there.
21 DR GROSSI: Okay. Felicity?
22 PROFESSOR GERRY: Yes, look, I think - I think - I hope that
23 there'll be a better understanding of what - of
24 vulnerability. I don't think Brett was trying to suggest
25 that what I was saying was absurd, but I think it would be
26 absurd for everybody to come out and think it's all going
27 to be hunky dory. There is a real risk to the elderly.
28 I think the point I was trying to make was that
29 there are so many vulnerable groups in society that I
30 really hope that the new normal will be some respect for
31 that, some respect for human rights, some understanding

1 that we all have a right to health. But there is some
2 importance in not being criminalised for going around your
3 daily - your day to day behaviour, not being restricted
4 from assembling and protesting about the things that
5 really matter to you.
6 Thinking about people in prison has been the big one
7 for me. I've been involved in the open letters to
8 Government to release prisoners and to reduce the high
9 incarceration rates, particularly of First Nations people,
10 and I think this is an opportunity for governments to see
11 where structures including justice systems create
12 vulnerability. So I rather hope the new normal will be a
13 real understanding of fewer restrictions in those types of
14 areas, and better recognition of human rights,
15 particularly for vulnerable people, so that's my eternal
16 hope.
17 DR GROSSI: Thank you. And Professor Sutton?
18 PROFESSOR SUTTON: I certainly hope that we come out of this
19 with new positive reflections, you know, around that idea
20 of the virus exploiting all of those gaps. I hope that we
21 can address some of those profound inequities that the
22 virus has shown up in society. And so, you know, if
23 there's a positive for me, it's that it has shown us some
24 of those significant vulnerabilities, and an opportunity
25 to address them.
26 You know, I think part of the response to
27 homelessness should be a reflection for all time. You
28 know, which is that people with insecure living
29 circumstances, and some who have literally been on the
30 streets continuously for months, shouldn't be tolerated by
31 society. We should find ways to find a long term and

1 sustainable solution for all of the health and
2 psychological and social benefits that that brings, and so
3 I hope that's a continued reflection out of this pandemic.
4 DR GROSSI: Yes, that's great. We've just got a few minutes
5 left for some questions that have been coming through from
6 the audience. If you're happy, we'll just take a few
7 questions. The first one is for Professor Sutton.
8 Given that elective surgery alleviates much pain and
9 suffering, and reduced physiological function, and given
10 that patients often interact with their GPs looking - when
11 they're having some sort of elective procedure, and then
12 have access to the hospital system, and things are
13 uncovered like undiagnosed anaemia or heart disease or
14 diabetes, would you consider advising the Andrews
15 Government on lifting some restrictions on elective
16 surgery sooner rather than later?
17 PROFESSOR SUTTON: Yes. I think it's another balancing act.
18 Obviously there's been a restriction where the most urgent
19 surgery has gone ahead, but lower priority surgery has
20 been suspended for now. I think that's obviously a
21 reflection of the fact that that surgery isn't regarded as
22 as urgent, but some of it is clearly necessary, and it's
23 not to say that people aren't living with a certain level
24 of suffering or disability by virtue of not having access
25 to that surgery.
26 At the moment, I think we're just going through a
27 phase of plateauing with our hospital admissions. Maybe
28 it's peaking, and it'll be in the next few weeks that
29 really we'll get a view of whether that's stabilised, and
30 there is an opportunity to recommence some elective
31 surgery. I think the other interplay there though is

1 we've really needed the health workforce to surge into the
2 aged care sector and the disability care sector, and so
3 that's the other constraint in terms of elective surgery.
4 It's not just the hospital beds and the theatre space as
5 it were.
6 So I think we need to get over that hump as well.
7 The active number of healthcare worker infections also
8 appears to have peaked, but there are still hundreds and
9 hundreds of staff in furlough, so I think we need to get
10 through that just in the next couple of weeks.
11 DR GROSSI: Okay, thank you. Question for you, Stephen,
12 regarding - given that there's a significant cause or link
13 here with zoonoses, do you think wet markets should be
14 banned and more restrictions put in place to prevent these
15 - you know, thousands of potential viruses coming across
16 and infecting humans?
17 PROFESSOR KENT: Yes. I think wet markets have seen their day
18 hopefully. I mean, culturally - again, I'm not an expert
19 in this. Culturally wet markets are quite - have proven
20 over decades to be quite difficult to shut down for a lot
21 of reasons, but surely if there was ever a reason to shut
22 them down now, this is a good time. There's, you know,
23 environmental benefits and health benefits. It's a
24 no-brainer.
25 DR GROSSI: Okay. We've got another question. I'll throw it
26 open to the panel. Have we quantified the harm of the
27 lockdown?
28 PROFESSOR GERRY: I don't know. Go on, Brett, you go first.
29 PROFESSOR SUTTON: Look, for me, no, not yet. They're not easy
30 dimensions to quantify. Clearly we're looking at those,
31 we're trying to capture them. Safer Care Victoria and the

1 broader department are trying to look at all of the
2 metrics, all of the data that might help support and
3 understand some of those other harms that relate to
4 domestic violence, that relate to access to essential
5 health services, psychological wellbeing and overall
6 health, especially for those with chronic and complex
7 illness.
8 One of the things in the balancing act is that, you
9 know, public health is in the business of making things
10 not happen. So it's not simply a case of the harms that
11 we're seeing through the lockdown balanced against the
12 harms that we see manifesting at the moment. It's the
13 potential harms if we let this virus run. You know, the
14 modelling has suggested that there could be 15 to 20,000
15 deaths just in Victoria. We've got lessons from overseas.
16 You know, India's got 70,000 cases per day. There are
17 four or five countries that have 1,000 deaths per day, and
18 that's not inconceivable for Victoria. And so there is a
19 balancing against what could happen.
20 PROFESSOR GERRY: And I think I'd like to add to that. It also
21 depends on what question you ask. So if you go back to
22 what I said about prisoners, are we counting the effects
23 on prisoners in extensive lockdown, for example? So
24 trying to measure is just really hard. I'm quite a fan of
25 the taskforce as well.
26 But, you know, if you set up a body that involves
27 experts in an area, that you can then think about what
28 questions you're going to ask. So I asked very, very
29 early on for a taskforce in relation to the release of
30 prisoners, and that's an example of where - you know, what
31 questions do you ask in order to collect the data?

1 And it's really difficult but, you know, if you have
2 a taskforce with that in mind, your numbers for infections
3 can't be balanced against the numbers in prison. You have
4 to try and work out what's the best approach for everyone
5 to have their highest attainable standards of health, and
6 it's an inevitably very complex question that I'm not sure
7 the data can always answer. You simply have to take some
8 tough decisions.
9 DR GROSSI: Well, anecdotally, I think we are seeing sicker
10 patients in hospitals at the moment, and I suspect that
11 once lockdown's finished, there'll be quite a high demand,
12 pent-up demand for procedures, but also chronic conditions
13 that probably haven't been managed as robustly as they
14 would have by their general practitioners had no lockdown
15 been in place, so I'm hoping that we'll be able to meet
16 that demand to treat the people safely.
17 PROFESSOR SUTTON: I'm also anxious that we might be seeing,
18 you know, the chronic effects of coronavirus infections
19 for the, you know, now close to 20,000 cases, and the
20 20 per cent of those who've had severe illness, I think
21 we're going to be increasingly cognisant of the disability
22 that they're carrying on with.
23 DR GROSSI: I'm mindful of the time. I really want - a
24 heartfelt thanks to all the speakers that gave up their
25 Tuesday evening to make this session quite special for us,
26 so thank you very much. I really appreciate your time and
27 your thoughts, and hopefully we will get through this
28 safely, and embrace the new normal together. I'll hand
29 over back to Will.
30 PROFESSOR SUTTON: Thanks, Antonio.
31 DR GROSSI: Back to William Edwards. Thank you.

1 PROFESSOR GERRY: Thank you.
2 MR EDWARDS: Good, I'm back. Gosh. Look, thank you.
3 I thought that was a wonderful roundup. Thank you to
4 everyone, thank you to our speakers, to Stephen, Felicity
5 and Brett, and to Antonio who sat in the corner and foxed
6 things very hard. I thought he did brilliantly. As
7 I said earlier, this is a new technology, and I've been
8 struggling in the background trying to fox questions.
9 Please forgive me if I haven't forwarded your question,
10 but there are multiplicity of them, and I can only type so
11 fast.
12 We need to thank in the background also Christopher
13 Ott, who's a member of neither society, but I've dragooned
14 into letting this run, and I think has done a tremendous
15 job. And lastly, a little commercial, if you've enjoyed
16 tonight, our societies are wonderful. They're great fun,
17 great ideas. Join. They're brilliant. Have a good
18 evening everyone, bye now.
19 - - -