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CRIME AND CORRUPTION COMMISSION

TRANSCRIPT OF INVESTIGATIVE HEARING

CONDUCTED AT LEVEL 2, NORTH TOWER, 515 ST PAULS TERRACE, FORTITUDE VALLEY WITH RESPECT TO

File No: CO-18-0360

TASKFORCE FLAXTON
HEARING NO: 18/0003

DAY 13 – WEDNESDAY 30 MAY 2018
(DURATION: 1 HR 35 MINS)

LEGEND

PO Presiding Officer – ALAN MACSPORRAN QC
CA Counsel Assisting – GLEN RICE QC
INST Instructing – AMANDA BRIDGEMAN
HRO Hearing Room Orderly – KEEGAN ENEVER
W Witness – JOHN WAKEFIELD
CM CHRISTOPHER MURDOCH, Crown Law (QCS)

PO Good morning, Mr RICE.

CA Good morning, Commissioner. I call Dr John WAKEFIELD.

PO Doctor, would you prefer to take an oath or an affirmation?

W An oath.

HRO Please take the Bible in your right hand and repeat after me.

W The evidence which I shall give in these proceedings shall be the truth, the whole truth, and nothing but the truth, so help me God.

CA Is your name John WAKEFIELD?

W It is.

CA You are a medical practitioner, Dr WAKEFIELD?

W I am.

CA You also occupy the position of Deputy Director-General of the Clinical Excellence Division within the Department of Health?

W That's correct.

CA Did you receive a notice to attend the inquiry?

W I did.

CA Can I show you this copy. Is that a copy of your attendance notice?

W Yes.

CA Thank you. I tender that.

PO Exhibit 93.

ADMITTED AND MARKED EXHIBIT 93

CA Would you mind just explaining the content of your role as Deputy Director-General?

W My role as Deputy Director-General of Queensland Health is really twofold. One is as a member of the executive team for Queensland Health, the Department of Health, with my colleagues, deputies director-general and the director-general, and our collective role is defined under the *Hospital and Health Boards Act*, which is really as stewards of the public health system and all its components.

My specific role as head of the Clinical Excellence Division is probably best broadly described as being responsible for assurance of patient safety and quality across the system through a number of mechanisms, including the measurement and a significant role of support, improvement support, across the health service delivery organisations that we call hospital and

health services.

Specifically around offender health, my role is very recent, and the director-general asked me to take a lead in a strategic review of offender health services. That is quite a recent role that I have come into.

CA We are particularly interested in that, of course, so we might come to that in due course. You had earlier occupied a position of Executive Director of Medical Services in Children's Health, Queensland Hospital and Health Service?

W Correct.

CA You are also, I think, an adjunct professor of public health at QUT?

W Correct.

CA And not least, you have been awarded a Public Service Medal in 2011, I understand?

W Correct.

CA For services to patient safety?

W Correct.

CA The area of interest of the inquiry is the delivery of health services to the offender population in Queensland. Responsibility for that has taken different forms over the years. I just want to ask you, if you can, to give us a little bit of a history as to the models for responsibility of that function, commencing, perhaps, prior to 2008?

W As part, obviously, of my role leading the strategic review, that involved developing a full understanding of the current state and historically how offender health services have been delivered.

The summary of that is really three phases. In the first phase, pre-2008, offender health services were part of corrections services. From a departmental perspective, the staff and the delivery of those services into prisons was owned and operated by the Department of Corrections.

CA Does that mean that doctors, nurses, and so forth, who provided health services to offenders were employees of QCS?

W Correct, correct. In 2008, I am advised that there was a machinery of government change, which transferred offender health services to the Department of Health, ie, transferred the staff, the employees, and the responsibility and governance of the delivery of those services.

At that time, that transfer occurred to the division which was then known as the Chief Health Officer's Division, part of Queensland Health, and at that time Queensland Health was one single organisation; that is, all the health services and the department were one in a legal sense.

The way that health care was delivered into prisons from 2008 to 2012 was what we would know as vertically integrated. In other words, both

the policy and governance functions centrally and the delivery into prisons was all directly run and accountable to the Chief Health Officer. There was a Director of Offender Health, a medical officer, at the time, and those services, whether it be policy, planning, training, education, standards, et cetera, monitoring, as well as delivery, were all part of the one organisation, if I can put it that way.

CA Insofar as prior to that, health service providers had been employees of QCS?

W Correct.

CA With the responsibility being transferred to the Health Department, what happened to the staff?

W Essentially, my understanding is that they were all transferred. In a sense, the only real change was that the ownership and operations of the service shifted to a senior executive, the Chief Health Officer, in the Department of Health from the relevant Department of Corrections. But the actual operations were - essentially just the employer was shifted.

Associated with that, I understand there was an agreement, a memorandum of understanding, that was struck between Health and the Department of Corrections for essentially the operations of those services in respect of corrections.

CA Come 2012, there were some substantial reforms. Are you able to say how those health reforms impacted on the delivery of health services to the offender population?

W I think in short, significantly. With the changes, which were part of national health reform changes but also changes under that banner that were specific to Queensland, two things happened.

The first one was that there was a new Act, the *Hospital and Health Boards Act*, which essentially saw a major shift in a legal sense to how health was operated in Queensland, such that instead of being one organisation with one bank account and a single legal entity, there was a split, a funder/provider split. So the Health Department retained functions such as funding and certain stewardship, policy setting, et cetera, roles. All of that, the 16 hospital and health services were formed, that were board run and independent sovereign entities, and a couple of other agencies as well, support agencies.

At that time, offender health service delivery, so the people on the ground that actually went into the prisons and provided health services - their employment shifted again to these individual health services, the eight hospital and health services, within which the corrections facilities sat.

I think the particularly important issue, that I think we will come on to next, is that there was no retention of any central governance within the Department of Health.

CA Would it be too simplistic to say there was a significant decentralisation of responsibility for health service delivery?

W Correct. The pendulum, if you like, swung from a centralised model, which was run centrally and operated centrally, including service delivery, through a completely decentralised service in eight hospital and health services, with no central footprint at all in the Department of Health.

CA Do we take it that was not a reform which was confined in its operation to delivery of health services to the prisoner population but to the population generally?

W Correct. I think it's fair to say - and this is my interpretation - there was a strong push to decentralise and take away any central functions, even statewide functions, such as offender health, but there were others that were located in one of the health services. For offender health, West Moreton Health Service, which has probably the bulk of the corrections facilities, was notionally allocated a sort of statewide role as well as the delivery role, but I would have to say that it's very difficult for a single sovereign organisation to discharge that central accountability.

CA This decentralisation was no doubt done with benefits in mind. Are you able to explain what was the driver of that model?

W There was obviously a philosophy around that, as part of national health reform, that care was better if the match between accountability and authority was held closer to communities; and the establishment of boards that essentially were accountable, similar to the *Corporations Act*, for the operation of health services, including offender health, was deemed to be better and more responsive to communities if it was local.

CA What is the manner of administration of each of these individual health services?

W What happens is that essentially there is a funding formula that the Department of Health uses to fund offender health services, which is on a cost per prisoner. That was calculated at the point of devolution and then has been continued thereafter with growth. That is part of a very long and complex contract which is struck every year between the Department of Health and each hospital and health service.

For example, West Moreton would have, in that contract, a line which related to funding for offender health services based on that model. Beyond that, responsibility for delivery and administration rests with the West Moreton Health Service.

CA And so on, through the range of other hospital and health services through the state that might take in within their catchment, so to speak, particular correctional centres; is that correct?

W Correct. The net result of that is that the Department of Health has very little visibility of anything beyond that transaction.

CA It is now focused on contractual arrangements and funding as opposed to delivery?

W Correct. That is not an offender health focus. That is a funder/provider focus between the department and a health service. Offender health is one

line in, as you would imagine-

CA Yes, a much broader picture?

W -hundreds, if not thousands, of lines of transactions.

CA Within that area of specialty, if I can call it that, of services to the offender population, it is based on a per head formula; is that the way it works?

W Correct. The department provides a cost per prisoner, standard cost per prisoner, which is another issue, which I would be happy to elaborate on, which is not necessarily deemed the best way to do that because it is not necessarily reflective of the cost of different types of prisoners and different types of correction services. Nonetheless, that is the basis of the current transaction, and the decision about how to deliver those services on the ground - doctors, nurses, when, how, what is delivered - rests with the local hospital and health service.

CA Accepting that, there are nonetheless some general standards or aspirations for delivery of services to prisoners, are there not?

W Yes.

CA Reflected, for example, in the so-called Nelson Mandela Rules?

W Yes.

CA Are you familiar with that?

W I am. On the question of what standards guide the delivery of health services into prisons, the United Nations has a commission that, as part of the United Nations, has established what is colloquially termed the Nelson Mandela Rules. There are many components to it, but the essence of it is that prisoners should have the same basic access to health care as is available to the general community.

There is another important component of that, which is that prison health services, offender health services, are best separate in a structural sense to corrections, which, I guess, is perhaps part of the trigger for the changes in 2008, that they are best administratively separate to corrections.

The third important issue there, which I think is pertinent, is that health services to prisoners should be concerned with not only, if you like, the treatment of the health needs of prisoners but also the improvement of the health of prisoners.

Finally, another important point is that prisoners should be entitled to confidential medical assessments, so in the absence of corrections staff, to create an environment where there can be trust between the doctor and the patient.

CA What status do these Nelson Mandela Rules have in the delivery of health services? Do they have any legal status or are they simply signposts?

W My understanding to date is that they are not legally binding, but I'm not an expert in that area of law. They are more sort of an international

benchmark of a set of principles which it is deemed to be reasonable to assess local services. But I can't answer honestly that I am fully across the legal status of those.

CA Is it reasonable to expect that the boards of the various hospital and health services would be aware of these benchmark standards?

W I don't know the answer to that question.

CA I'm just wondering to what extent they would be generally accepted as themes for the delivery of health services to prisoners.

W Without those, there is really little to guide the design and the delivery of health services into prisons. I think they loom large in that sense in offender health services, and they are certainly well known to those offender health service delivery arms within the health services. But at the level of the hospital and health boards, I can't speak for the level of visibility or knowledge that the boards have of those.

CA Are there particular physical or mental health issues that are likely to accompany a prisoner population?

W Sorry, may I just qualify my last answer? Whilst my last answer stands, hospital and health boards have a legal duty and accountability to their role, which would extend to prisoners, recipients of offender health services. So they certainly have the duty; but the knowledge, I don't know. Sorry, could you repeat that question?

CA I was asking you whether the prisoner population presents particular mental health or physical health issues?

W Prisoner populations are incredibly vulnerable. Perhaps if I can just go through some high-level statistics, if you like, about prisoner populations in the context of a comparison with the general population.

In terms of the prisoner populations, roughly 90 per cent of them are male and 10 per cent are female. Their average age is around the mid-30s. The rate of incarceration of those, how many people are in prison, is around 220 persons per 100,000 population, but the key difference is that the indigenous population is 10 times more likely to be in prison. Whilst indigenous represent about 3 per cent of the population, they represent about 30 per cent of the prison population. So it's not possible to talk about some of the challenges of the prison population without specifically dealing with challenges of the indigenous.

CA Are the challenges for the indigenous population different from the remainder?

W They are magnified. Everything that one would say about a non-indigenous prisoner population would be magnified for the indigenous population.

Just coming to the actual health concerns - first of all, the social status of prisoners is significantly low, their rate of education or achievement, their homelessness. About 30 per cent of prisoners report being homeless in the weeks prior to going into gaol.

Mental health looms large. Around 30 per cent report, upon entry to prison, that they have a diagnosed mental health condition, and around 50 per cent of the prison population at admission are on some kind of mental health medication, whether that be an antipsychotic, an antidepressant medication or something to manage anxiety.

They have significant drug and alcohol and substance abuse issues, such that, again, a significant proportion report using illicit drugs or having problems with alcohol.

When you look at the infection risk in prisons, 30 per cent of prisoners test positive for Hepatitis C, so if you're talking about blood-borne viruses, which are often associated with injecting drug use and unprotected sex, 30 per cent of them - and it's actually more in women - are Hepatitis C positive. Hepatitis C is a particularly aggressive disease that essentially ultimately causes liver cancer and death and now presents a huge opportunity for us, because we have a drug now that can eradicate Hepatitis C. So that's another opportunity.

HIV and Hepatitis B similarly are problematic.

Forty-five per cent of prisoners, upon admission, report a current use of IV - of illicit drug use, injectable drugs. On testing, 75 per cent of prisoners, on entry, have evidence of some kind of drug, or at arrest usually have some kind of illicit drug on board.

So this is a particularly vulnerable group from a social and determinant of health perspective, from a behavioural perspective in terms of poor health behaviours, and also chronic disease. A significant proportion of them also report having some kind of chronic disease upon entry. What do I mean by that? Asthma, diabetes, arthritis, heart disease, and so on. So this is a hugely vulnerable group. Ordinarily, they would be very high users of the health system.

CA How does the delivery of health services, physical and mental, actually work in practice? To the extent it is necessary, you might need to touch on whether different methods have developed across the different hospital boards?

W Yes. As I have already said, each health service runs its own service, so there are differences. Equally, though, the prison populations and the corrective services facilities are very different. For example, in Townsville, in the north of Queensland, the prison population can be 70 per cent indigenous, whereas that is different down in the south-east corner.

Plus, some corrections facilities have very little turnover, so a person goes there after their sentencing and stays there. And others have a high turnover, which presents significant challenges for health service delivery.

So how does it basically work? If I can separate mental health and oral health, because they are provided slightly differently, the basic health services are what we would call primary health-type services, the sorts of services that you would get in general practice, in the community. It's just

that, obviously, prisoners can't access those unless we provide them. They tend to be nurse led. There are doctors, but they tend to be predominantly nurse led. Whilst seven days a week, they tend not to be 24/7, in many cases. They tend to be conducted inside the prison out of a small health-type facility. I can only speak for those that - I have only visited one, but certainly I hear from many that they are cramped, out of date and really challenging environments. Essentially, prisoners, upon entry to a particular service, line up and get an assessment.

CA Are you talking about introduction to the centre?

W I'm talking about a prisoner that's transported to a particular corrections facility gets an initial assessment. Every prisoner gets an initial assessment.

CA Is that standard, do you know, the form of assessment and screening that takes place at reception?

W I can't answer that. I would expect that it would be, but I don't have the data to be able to confidently say so.

What I can say is that somewhat surprisingly to me - and it's top of my list in terms of solving - there is no prisoner-centric information system. Bearing in mind that 60 per cent of our prisoners have been in before, and they obviously move around different centres, really, it is critical from both an efficiency perspective and a safety and quality perspective that if a prisoner comes in front of me and I'm a nurse in a particular corrections facility, I've got access to a record so that I know what the history is and what the medications are.

CA As, for example, a hospital would keep, or even a doctor's surgery?

W Correct.

CA And there is nothing like that?

W The answer to that is that there is no electronic system. So what tends to happen is that in dealing with paper, and particularly with the movement of prisoners through the system, in different corrections facilities, a lot of time is wasted, and I have heard lots of stories about that initial assessment requiring lots of time wasted to try to phone different places and get records and get information.

So they get that initial assessment and, on the basis of that, the basics will be done. For example, do they need mental health services? Do they need oral health services? Are they on any medications? What are those medications? Can they be prescribed in the prison? What are the likely outcomes? Do they have any blood-borne virus diseases and how are they being managed? Then, on the basis of that, whatever plan is put together and that forms the basis of care.

My understanding of how this works, in talking to the staff, is that, by and large, prisoners on a day-to-day basis - they are not allowed to keep their own medications themselves, so they have no choice, if they are on insulin or if they're on a three-times-a-day blood pressure medicine, or whatever it is that they're on, they come and see the nurse. They line up for their

medications. That's the way the predominant sort of daily care is delivered.

Obviously, if anybody is acutely unwell, so if anybody has something that happens suddenly and they get sick or they have pain, there is an emergency-type response system. So, again, the staff will then go to the person or the person will line up, depending on what the scenario is.

The most significant recent challenge to the delivery of that service has been due to the lockdowns because of overcrowding, wherein when half the prison population in a particular corrections facility is all of a sudden locked in the cell half of the day, these nurses then have to go and take the medicine to the patients. Sometimes they have to deliver that through a locked door, through a hole in the door, with multiple prisoners in a cell. There are all sorts of issues about identifying people. Frankly, because you can imagine that the logistics of that require significantly more time to get around and do that, there are times when people miss out.

CA Can I just go back to the record-keeping aspect that you referred to earlier. You referred to the assessment that takes place on reception.

W Yes.

CA That includes relevant medical data?

W Yes.

CA Do you know whether that, then, becomes part of the prisoner's correctional record; is that your understanding?

W My understanding is that it does, but because they're dealing with paper records, that then is resident in that facility. There is a central repository. Once the prisoner has left, it does go back to a central repository in West Moreton, as I understand it. I think part of the challenge - it would be fine, really, if prisoners tended to go to one hospital and stay in one hospital, but that's not how it works. So the movement and availability of information at the point of care, for people that deliver care, is a significant problem.

CA You said that the service delivery was nurse led. Can we take it that that is for the purpose of doing some initial screening by a nurse to determine whether professional intervention or treatment by a doctor might be required?

W That's correct. Nurses are well qualified to deliver the sort of primary care interventions that we are talking about. Doctors generally will need to prescribe. Particularly at the point of entry, every patient ultimately, if they're on medications, will end up seeing the doctor, but the nurses usually do the bulk of the work.

If a prisoner requires, either in an emergency or, more usually, in a planned way, health services which can't be provided in the prison - let's say a specialist orthopaedic surgeon or a neurologist, or whatever service - then they usually will be transported from the prison to either one of our public hospitals, depending on what that is, or particularly if it is in the south-east, there is a 12-bed facility at the Princess Alexandra

Hospital, which is used, I guess, to locate prisoners, it's secure, so that then those specialist services from the hospital can actually be provided to that prisoner on that campus. But there is only one, and that's at the PA Hospital.

CA How would a doctor or nurse determine a diagnosis or what kind of treatment is appropriate without historical records, if that's the situation?

W This is not unique to offender health services. I think, again, the population in general would appreciate the fact that if you go to access health care somewhere where you are not known, then often there is a bit of a challenge in pulling together that information.

That is slowly being addressed. The My Health Record is coming into place nationally. That is going to help matters. And certainly in the public hospital system, we have records that are now visible to everybody across the system, including GPs. But it is far from - it's a work in progress.

I wouldn't like to say this is unique to offender health, but it is true to say that if you don't have the history - so a person that comes in, going back to what I said before, a homeless person, who has lots of health problems, who may have been very transient and doesn't have good information on what they are on, there is a lot of time spent in chasing up the various services by those offender health service nurses and doctors, and there would be times, no doubt many times, where they essentially have to start again with the person.

Now, the person in front of them will be able to give them lots of information, but they may not know all the detail. "I'm on a blue pill and a red pill for my blood pressure" doesn't really help. So that's a problem. If you look at the complaints data that we get, which is also fairly scant, access to medications is one of those top three issues, where prisoners complain about that.

CA The majority of the prison population, from what you say, is on some form of medication?

W No, I think what I said was around half, or slightly less than half, but a significant proportion.

CA And, as you point out, prescriptions need to be written for medication.

W Yes.

CA Do prisoners need to see their doctor every so often, as the rest of the population does, to have prescriptions renewed?

W Again, going back to the Nelson Mandela Rules, that's the benchmark. It's true to say that, again, as services have been squeezed by the volume of prisoners and the overcrowding, and, as I said, particularly the consequential action of corrections in managing that overcrowding, it essentially restricts access of our offender health people to prisoners. That can create issues.

CA In terms of the method of delivery, do we take it that the nursing service and what we might all know as the general practice-type health service

delivery is done on site?

W That is correct. That is all done on site. Oral health services and mental health services are organised slightly differently but still come on site. But they're not part of that offender health service. They are delivered from another part of the health service. But, yes, they all come to the prison and deliver services to prisoners in the prison.

CA If there is a need for a specialist service or some hospitalisation, then that is done by special arrangement off site?

W Correct. Beyond that primary care and mental health and oral health, my understanding is that it is rare for specialist health services to go into a prison. It would tend to be the case that the prisoner is then taken to the hospital, where those are provided, which obviously creates logistic challenges and is responsible for some movement, I understand, around the state.

Prisoners either end up in that PA facility, which is specially designed, or they end up in a public hospital with a corrections officer and the relevant security around that, which can be confronting for other patients, obviously. So that is either for an outpatient clinic attendance, or if they need an operation or they need to be in hospital, then obviously there's no choice but to go to hospital.

CA At the level we have been speaking of, intervention of nurses, GPs, and then progressing up the needs scale to offsite service delivery, are there any variances across the various health services on that model that are noteworthy?

W Because with offender health services, the actual service delivery is not captured in the same way that we capture health data in the general system, I can't provide data. I don't know what, for example, the waiting times are in a particular corrections service for a particular service. I have no visibility of that.

At a local level, they keep their own data, but there is no central capture. There are no clear definitions. So I don't have access to that at the department level, which is part of the challenge, because unless we actually start to measure those things, we actually don't know; I can't say where the particular problems are.

CA If, hypothetically, a prisoner were to move from the area of responsibility of West Moreton, say, to Cairns, do the medical practitioners in the new location, in Cairns, need to essentially start from scratch to build a medical profile for that prisoner?

W My understanding of the process, clinicians are used to doing business. They are committed to - they understand the value of information. So at a point of transfer, ordinarily, just if we transferred a patient from a hospital to another hospital, there would be transfer information or what we call a discharge summary so that the people receiving the patient would be able to carry on or at least would know what drugs the patient was on, what problems they had, what tests they'd had done and the results, and so on.

CA That could be done between private doctors' surgeries also, could it not?

W That's right. That would be the way business would be done, but there's an assumption there that the decision of corrections to move someone incorporates both the time and the ability of the health staff to be able to do that. Again, I only have stories about that, I don't have data, but I know that's a problem. For various reasons, and they might be quite legitimate from corrections moving a prisoner, health may not be involved in that or may have insufficient time to do that.

In terms of the central governance, the project that I'm now responsible for, which is first to review in a deep sense all of that, so I should be able to answer some of those questions going forward, though I don't have the data at the moment, the delivery of an electronic information system statewide which is prisoner-centric, in other words, any health person in any of the prisons can look up a person, who is a single identified person across the system, is an absolute priority.

CA Would you be aware that corrective services operates its own database? It's called IOMS; that's the acronym. Are you familiar with that?

W No.

CA In terms of developing an electronic database of medical records, do you imagine that existing separately or as perhaps a feature of an existing database that might be within operation by corrective services?

W Because this will be clinical information, the legal obligations, as well as privacy and the clinical observations, I think would require that to be separate. However, it may well draw upon - and I'm sure corrective services would have a prisoner-centric database. A clinical system may be able to draw on the person identifiers, and so on, if you like, so that it is not completely separate, but the governance of the information in that system would not and cannot really be for corrections, because it involves a person's private information. There may be some components which appropriately are shared. I think the short answer is that it may be linked, but I think it would be certainly firewalled as a clinical system.

CA That raises the subject of information sharing. Would you accept it's not difficult to imagine a scenario where a person's diagnosis or health needs as identified would be quite relevant to the management of that prisoner within a correctional environment?

W Yes.

CA What's the answer to that?

W The first thing is, I would wholeheartedly agree with you that the relationship between corrections and offender health services is critical, and the sharing of information is critical where it pertains to decisions about a particular prisoner. Some of those decisions totally rest with corrections, obviously. That could be worked out as part of the design and governance of such a system, where not unlike information sharing with other organisations from health that we have - child safety, police, and so on - there would be captured in a memorandum of understanding or some kind of agreement items that should and must be shared, flags of

particular warnings and concerns. But there may be an intermediary with that, in other words, that may require a flag such that corrections seek the advice of a health professional in decision making about that person rather than just necessarily taking a piece of data.

So I think it should be done, but it would be done with caution and balancing the rights of the individual to confidential clinical information with the obligations of corrections to provide a safe place for staff and prisoners.

CA Are the barriers to information sharing simply philosophical, such as encapsulated in the Nelson Mandela Rules, that confidentiality is the desirable thing? Is there more to it than that?

W No, the law is pretty clear in terms of our obligations for patient confidentiality. Our staff operate under - the *Hospital and Health Boards Act* makes it very clear that it is an offence to divulge information about a patient to a third party without their consent. So that's beyond the information privacy legislation, which is federal legislation. I think the area is reasonably complex from a legal perspective. I don't pretend to be a lawyer, but it has been a major part of my career as an executive in the health system and as a clinician. That is very important. That is enshrined in legislation, and the penalties are fairly stiff for anybody that breaches that.

CA There are pretty obvious limitations to any kind of extensive information sharing, even where relevant to a prisoner's management?

W The first thing is consent. If a prisoner consents to sharing, that's fine. That shouldn't be forgotten about. Perhaps the default should be that we always seek consent to share that information.

Where that consent is not obtained, then I still think that there is a capacity to share information that is relevant. That could include, for example, rather than specific information that is divulged by a patient, it might be an assessment of risk by a doctor, for example, a flag about suicide risk or a flag about certain behavioural risks or mental health challenges or a flag about disability and the consequence of disability. It's not binary, but it needs to be carefully managed.

CA What about the prevalence of mental health issues amongst prisoners, how is that addressed with the delivery of mental health services?

W As I said before, the prevalence of mental health and mental illness in prisons - in prisoners upon entry, in a sense, part of a contributing factor to their being in prison is significant; and then once in prison, there is some research about the impact of prison on a person's mental health and mental well-being. Forty per cent of prisoners actually report that their mental health improves having been in prison, which was a surprise to me. It still means the majority report that it gets worse.

Of course, mental illness has a significant range from what we would call psychotic illness, so schizophrenia and really serious mental illness, through depression and anxiety and suicide, and doesn't necessarily map to any of those. Probably around half of the prisoners, according to our data, need a solid mental health assessment, they need a mental health

treatment plan, and they need access to a range of interventions through their stay to assist them in managing their mental illness and to improve, actually recover or seek to get better.

There are various issues that impact on the delivery of those services. Obviously, resources is one. The demand for resources certainly outstrips our ability to provide the sort of care that we would want to give. But I think, again, if we go to the specific issue right now of overcrowding and lockdowns, that is a huge issue. I visited the Women's Correctional Centre-

CA In Brisbane?

W -in Brisbane, and talked to women prisoners and walked through the different environments that they're in and talked to staff, corrections staff as well. Basically, overcrowding prevents access to both assessment and treatment and rehabilitation services.

CA Is it simply that there are too many to be seen? Like a doctor might have too many patients for the day and can't see them all, is it that concept?

W That's one. The physical environment for delivering the service in the little health clinic that they have is just too small. Obviously, demand - with 50 per cent overcrowding in the women's correctional centre and about 35 per cent in the men's, obviously the volume doesn't allow you to treat them there.

The lockdowns prevent any type of remedial work happening. When you have rolling lockdowns, which are now the norm, basically prisoners say that they can't access the things that they do which actually help them and which help recidivism reduce and help their mental health improve, such as programs. They can't actually go and access the programs, because there is a rolling lockdown.

Access - as I said before, not just the physical environment where they come to see the health service providers in the prisons, because of lockdowns the health staff have to go to them, so that really reduces their ability to provide anything other than medication, really. That's basically it.

When you look at what should we be doing for prisoners, as a captured population, with such significant issues, we should have a goal to eradicate Hepatitis C in the prison population. That is achievable now. We should have a goal to really tackle mental illness through captured programs, medication and support services whilst people are in prison. That's all possible if the environment supports that, but-

CA And infrastructure?

W And the infrastructure as well. Just to paint a picture, in a cell built for one, there's a bed, and then on the floor there's a mattress for the second person, and I had to walk over the mattress to get to the ablutions facility. There's no walking around. The mattress occupies the full width of the cell.

CA We have heard about that.

W In talking to one of the women, she said that the only time she can have alone is in the shower. And, again, there's quite good evidence that not having - whilst there's some protective element for some in terms of having someone else in the cell with them, as long as it is designed for two, there is a profoundly negative impact on the mental health of prisoners through essentially being never able to have a bit of space.

CA That is quite apart from, I suppose, an aspect of being in a cell.

W Yes. So you have this situation where you can't provide the services that they need, so they get worse, but also the overcrowding itself creates significant deleterious effects on mental health. And we haven't even talked about the issues of violence, the issues of other types of illicit behaviours, drug use, and so on. Again, there's not a lot of good research evidence, but I have a paper that I had a close look at, which really did show significant impacts of overcrowding on things like the propensity of prisoners to become violent and on the risk of just basic public health diseases, such as pneumonia, tuberculosis, as well as the blood-borne viruses from sexual behaviour, and so on. Overcrowding actually creates a worsening, in and of itself, of the health of prisoners.

CA You mentioned a little earlier the potential to achieve some high-level goals. Eliminating Hepatitis C was one. Is that sort of high-level goal-setting evident in the decentralised model?

W Again, I have a lens on this from where I am, and I have been doing this for the last three months as a component of my work. I would like to qualify my statement by saying this is my lens on the system. Others would have a much more focused and detailed lens. I think I have the benefit of (a) being a doctor, and that's obviously being a clinical practitioner but also having spent 15 years in systems and strategy, and (b) having the benefit of getting on the balcony and looking at this.

I think the big questions that I have, and the motivation, and I think where we need to go is, without some central governance in health, we just have a lot of orphaned services. They are very small services, and in a big hospital and health service, it is hard for them to compete for any air time in the local health service priorities and strategies. Therefore, there is no overarching goal and strategy for the health of the prison population.

But I think it goes well beyond health. Health is really at the end of the line. And corrections would say the same thing, I guess. Corrections have to deal with what they get served in terms of numbers. And then their actions, including, say, the lockdowns, and I respect the fact that they believe they have no choice to do - basically, we have to cope in a very reactive way to that.

If we flipped it around and said, as a society, we know recidivism is about 60 per cent; we have an opportunity, and perhaps an obligation, to take this very vulnerable population and actually turn it into some strategic goals for how we can really make a difference to the health and mental well-being and some other social factors and skills, and so on, and education, whilst they're in prison. We may actually profoundly change the cycle.

Unless we do that, unless we say we will eradicate Hepatitis C from the prison population, we will make sure that we commit to changing the mental well-being of prisoners, whatever those goals are, I think that we will continue just to react to whatever gets shovelled down. And I don't see that strategy, and that's one of the things that will have to come out of this review.

CA You are a central participant in the governance improvement project, are you not?

W Mmm-hmm.

CA In particular, you are the chair of what I understand is described as the Offender Health Services Steering Committee Alliance?

W Correct.

CA Abbreviated to OHSSCA?

W Correct.

CA What was the genesis of the governance improvement project?

W There were several things. I would call it a perfect storm. Perhaps as these things often do, it's essentially responding to a number of issues, and they are as follows.

First of all, I think the noise from the services and the health services, basically saying, "We need more money, because we can't cope with the demand." There was a sort of straw that broke the camel's back, which I said, which were the rolling lockdowns, which just happened and we had to respond to that, which really kind of broke - it took a very stretched service and broke it. So we had an immediate issue that we had to respond to and provide emergency resourcing to try to manage around that.

The second issue, and probably preceding that, were significant concerns from the office of the Health Ombudsman about complaints around the state from prisoners. Their view, it is fair to say, was that they weren't seeing strategic action from health in relation to those concerns. Bear in mind we don't see those complaints that go to the Health Ombudsman, but we certainly received advocacy from the Health Ombudsman about doing something. They in fact commenced their own investigation into offender health services, which they are continuing, but they have deferred some of the activities because they're part of this strategic improvement project.

The Queensland Audit Office also undertook a review and there were some recommendations arising out of that, the deadline for which has now passed, in relation to offender health services and particularly from a central governance perspective and also the informatics perspective.

Finally, the Barrett Commission of Inquiry, which was the inquiry into the closure of an adolescent extended mental health facility in West Moreton, gave some recommendations which went well beyond adult mental health and went to how the system governed statewide services, and offender health was one of the services mentioned. Essentially,

I guess that flagged, well, devolution swung to another - the pendulum swung completely, and if you have a statewide service, then it's hard to imagine that you can effectively provide that, particularly across multiple sites, if you don't have some kind of central governance, even if delivery is local, some central governance to manage policy and standards, training, research, practice, and so on, informatics. In today's world, that is not possible.

All that came together such that the director-general asked me to lead essentially this departmental approach to improving offender health services.

CA That's the governance improvement project?

W That's right. The membership of that committee includes - and corrections have been extremely supportive. Corrections also want this, and so our relationship is good. The Commissioner and the Deputy Commissioner are on that committee, as are the Queensland Nurses and Midwifery Union. We have health consumers, including some of the consumer groups that feed into that as well.

CA Are stakeholders viewing it as a positive opportunity?

W Absolutely. I think they remain cautious and I think they want to see outcomes. At this stage, we are very much in the diagnostic phase: what are we dealing with and what opportunities are there? But, yes, we can't do it without them. They have to be there, and obviously we have providers, so the people who are accountable for providing offender health services, whether it be chief executives and people on the ground, who can really tell us how it is.

CA You have mentioned already, I think, there is some form of review in progress. You mentioned you are in the diagnostic phase?

W Yes.

CA Perhaps you might give us the content of that?

W I am happy to tender the terms of reference for that review, if that's helpful.

The committee agreed upon a set of specifications and we believed, because of the scope of this review, that we needed to bring in external assistance. PricewaterhouseCoopers were the successful tenderers for that review, which is occurring right now.

In essence, that review will explore in detail what is happening in every service. We didn't just want to keep that at the top level; we wanted to know what's happening in every offender health service, because they are different, and we wanted to understand the models of care that were being used and whether there was any opportunity for improvement.

The efficiency of those models, there are some questions about - there are two private corrections facilities, and they have agreed to participate. We are keen to understand how they run their services and what we can learn.

As well as an assessment of best practice around the world - for example, medication practices. Some services now in New South Wales have limited medications that prisoners actually hold themselves and administer themselves.

We want to explore all of that before we then land upon a plan of improvement, which we will be taking to CBRC to see if that requires any additional funding.

I would like to state - and this is why corrections, it is really critical, are around the table. I have a view - this is not necessarily the department's view, but I have a view that any submissions from a corrections perspective really need to incorporate the health perspective. It is very difficult - I think it's not sensible, for example, to consider submissions from corrections to build prisons or to do anything else without considering the health component to that. To consider that separately I think is risky.

I do see out of this a significant change both to delivery on the ground, but also the other part of it is what does central governance look like. I can say the director-general is - I mean, we will be having a central footprint. The question is what will that look like and what will it do.

CA You mentioned you were happy, I think, for the terms of reference to be made available. Can I show you this, Dr WAKEFIELD. Is that a copy of the committee's terms of reference?

W Correct.

CA I tender that, Commissioner.

PO That is Exhibit 94.

ADMITTED AND MARKED EXHIBIT 94

CA Is the first part of the project to have this review conducted by PriceWaterhouse?

W Yes. There are two phases. The first phase is to, if you like, have a state of the nation, what are we dealing with? Then the second phase will be an implementation plan, which, again, will clearly involve decisions of government. The end of the first phase we anticipate being midway through perhaps the second half of 2018. I think we have a late-July deadline, but my sense is that it's very tight.

CA It is a big project, is it not?

W It is, and I don't want to compromise the quality of that work by some artificial deadline. So we will be prepared to extend that if, for example, the logistics of all the work encounter some delays.

CA Can you tell us whether the results of that review are likely to be made available outside the department or the committee?

W That will be a decision for the minister. My view is that that's highly

likely, or certainly a high-level report will certainly be made available in the public domain.

CA Where do the private providers of correctional services, GEO and Serco, fit in to this scheme?

W This review was commissioned under the powers of the director-general under the *Hospital and Health Boards Act*. Of course, the private providers are not captured by that head of power, but I was very keen to just ask them, respecting the fact that they were not required to do so, would they be willing to do so, and they were very willing to participate.

So they are not formally on the steering committee, but at the level of the work of the consultants and the review, they have agreed to participate certainly in an exploration of models of care, in the economics of the health service provision. I see them as a very important stakeholder. We may well learn from them, and vice versa. That's the relationship that we're seeking to manage, with the help of corrections. Actually, they are clients, essentially, the contractors, corrections, and so Peter MARTIN has been very supportive of managing that relationship.

CA Those providers, under their contracts, are responsible for delivery of at least a certain proportion of the overall health needs of their population; am I right?

W Correct. I think excluding mental health and oral health, which is provided, as I understand it, under the similar model of the public.

CA Will those providers, then, be participants in the committee? Are they stakeholders at that level?

W They're stakeholders. We've chosen not to have them on the steering committee, because I guess contractually in respect of corrections, Peter and I felt that they're stakeholders, so they are very much included, but they are not actually on the steering committee.

CA Is it possible that either or both of those providers is managing their health service delivery in a way that Queensland Health could learn from?

W It's certainly possible.

CA In other words, is the opportunity there to tap in and see if there is something good?

W Absolutely. As I said, whilst we weren't compelling them to do so, we were inviting them to do so, because of that very reason, what could we learn from them, and vice versa.

There may be constraints that we operate under, whether it be industrial or otherwise, that mean that we can't. But if we don't know how they do business, and vice versa, then we won't know whether we can do it.

So the privates, yes. I think one of the things that we're really keen to do - and at the last meeting, we spent two hours really looking at all the international best-practice evidence that PWC had exposed, and there's a lot to learn from. Health tends to operate in an evidence-based policy

frame. I wanted to make sure we were applying the same rigour, and if we can learn from Norway, if we can learn from the UK, if we can learn from New South Wales, then we must. There were a number of things that came up in that work that I think is promising.

Indeed, even within Queensland - for example, Lotus Glen has a fabulous program in the Hepatitis C eradication space, and we must learn. This is part of the issue. We must be able to spread that sort of good innovation across the system, because they're not learning enough from each other because they're separate from each other. There is lots of opportunity for us to do business differently.

CA Thanks, Dr WAKEFIELD.

That is the evidence, Commissioner.

PO Thank you, Mr RICE.

Doctor, just a couple of things. When the prisoners are first coming into a facility and they may have been at other facilities, as you say, given the difficulty of information sharing or the availability of the history of the patient, the initial assessment which is done is critically important, is it not? Don't for a moment think I am denigrating the quality, qualifications or work ethic of nurses, but is it potentially a risk to have that critical first assessment done by nursing staff rather than medical staff - doctors?

W I would say no, Commissioner. There is plenty of evidence that well-trained nurses are - they have a significant domain within that sort of primary care, and assessment is very much part of that. What's important is that they have a team and that the balance - you know, that there is medical leadership as well as nursing leadership in the team, and that they appropriately apply medical expertise and nursing expertise where it's needed. Just as not everybody in the community needs to see a doctor all the time, that's not the case in the prison community, either.

My response to that would be that so long as they have, at a local level, a very clear protocol for what the nurses do and how medical expertise is used and how accessible it is and if it's appropriate, then I have no problem with that.

PO The medical staff are employees of Queensland Health, the various hospital health services.

W Correct.

PO Do you have any difficulty obtaining staff to go into prisons? Is that a particular issue for health?

W Most definitely. Again, I don't have data. I will have, hopefully, after this strategic review. But certainly, anecdotally, there are significant challenges recruiting and retaining staff, which does go to your other point about-

PO Expertise.

W -the quality and expertise, I suppose, of staff. If you've got transient or

agency-type staff, they are not going to have the same level of commitment to the service. Clearly, this is a challenging environment. It is an alien environment for clinical staff, and you need people that really want to be there and have a passion for being there.

I think recruitment and retention is an issue, but, again, I think the more structural environmental challenges we place on them - they want to do a good job. They are trained to do a job, and they want to do that and they want to improve health. I think that the more that health in prisons is deconstructed to something which is highly reactive and where some of those constraints just get in the way of them doing a good job, people leave. It all gets too hard. Again, the better the environment we have for prisoners, I think the better the environment we have for staff as well.

One other thing I would say in response to that question or comment is that central governance allows you to have leadership in a clinical sense as well as policy and resourcing, those other structural issues that are really important. You are never going to have a statewide electronic information system if you don't have central leadership. You are never going to have standards and measurement of quality and training and research if you don't have central leadership. That central leadership needs, again, in my view, to be that sort of triad of really expert operations, sort of, management experience, systems and support, expert medical, offender health experience and expert nursing experience. Without that, you don't get the strategy and the drive to actually get ahead of the reactive stuff. I think the clinical leadership is not just about doctors on the frontline; it is about doctor leadership.

Between 2008 and 2012, that was very evident, in my view. I wasn't part of the system, but I was aware of what happened, and standards and training and bringing people together to apply that really, really improved things.

PO That is when there was the centralised system?

W I wouldn't call it centralised. I would call it a combination of - I would call it a system with a central component and distributed components, is really what we need. Moving everything back into the centre is not necessarily a good thing, either.

PO You mentioned just a little while ago in answer to Mr RICE that you had noticed - and you quoted the example of Lotus Glen, which had a very good system in certain respects, but it wasn't being shared with other centres, who were all running their own shows. We have seen that repeatedly in the evidence here, that each of these prisons operate with a large degree of autonomy. A lot of them have very good ideas that work and that would not just be limited to that centre but would be relevant across the sector, but there is not enough, it seems from what we have heard, sharing of what works and what doesn't work. It seems it is the same in the health services area.

W That is my view. Again, you may get different opinions about that, and this is where that polarity comes, the polarity between wanting it centralised versus wanting it devolved. Most complex systems and delivery systems in health or otherwise really require a central component and peripheral components and a sort of democracy of all those players,

with a focus on improvement, so rather than a central thing saying, "Everybody shalt do this a certain way", that looks like a - together the system leader and the delivery arms coming together and working, planning together, sharing improvements.

It was one of the first questions I asked: do the leads of each of the offender health services get together every quarter, every six months, or whatever, and create that environment for just, as a network of people, sharing from each other, sharing problems, solutions, picking up innovations? And the answer was no.

They can do that without a central component, but it's hard, and I think it's much better if everybody is together centrally and peripherally. That's where innovation spreads, but that's where also, I think, people get the support that they need in a difficult environment.

I think that will make a profound difference, and it's absent at the moment as a consequence of essentially saying that central is bad; everything has to go out. So that's my view. Again, from the director-general's perspective, I think he is very clear that there will be a central footprint, and I guess it's my job, with the team that I'm working with, to try to define that in a way that actually makes things better and not worse.

PO Can I ask, finally, with the review you are currently undertaking, the first stage is due for completion around July, subject, as you say, to the necessary extensions if that becomes an issue. What is the overall time frame? Is there a general finish date that's nominally - I won't hold you to this, I should say.

W The reason we chopped it into two was because we have control over the first one and less control over the second one. I don't like to commit to something that I don't have control over.

I think what we can say is that before the end of this calendar year, subject to the decisions of government, we will have an implementation plan, and that implementation plan will have its own time frames. There may be some things which have a very short delivery time and there may be some things which go out one or two years down the track, or even longer.

That would be my answer. I would expect by the end of the calendar year - hopefully before then, but realistically by then - I think it is a reasonable expectation that there will be an implementation plan which is approved by, obviously, our minister and by cabinet, as it probably will require some kind of commitment in a resourcing sense.

That will be a sort of blueprint that can take us where those milestones are defined. Then those questions can be more specific: "John, when there will be an information system?" I have already commissioned the work on that, and I'm optimistic that within 12 months, we'll have that in place. Some of those things will be shorter and some will be longer. Does that answer your question, Commissioner?

PO It does, thank you.

Yes, Mr MURDOCH?

CM May it please the Commission, just a couple of matters.

Doctor, you mentioned that presently the system is that the individual hospital and health services provide health services to the prisons that are within their geographical jurisdiction.

W Yes.

CM It is the case, is it not, that each of those respective hospital and health services enters into a memorandum of understanding with Queensland Corrective Services, and that document sets out the respective responsibilities of the hospital and health service and the QCS in respect of those centres?

W I haven't seen those, but I understand that has happened. There was one and now there are many.

CM When you say "many", there is one that exists in respect of each hospital and health service board that provides the services to each of the respective prisons?

W As I understand it, yes.

CM You also mentioned information sharing between Queensland Health and QCS. It's also the case, is it not, that there is a separate memorandum of understanding as between Queensland Health and Queensland Corrective Services in respect of the sharing of confidential information in relation to their respective responsibilities?

W I don't recall having seen that. That's an important issue, so I take your word for that, but I haven't read it or seen it.

CM No further questions.

PO Thanks, Mr MURDOCH.

Anything arising, Mr RICE?

CA No, thank you, Commissioner.

PO Thanks for coming, doctor. You are excused. Is that a convenient time?

CA Shall we take the morning break, Commissioner?

PO We will come back at about five to, thanks.

END OF SESSION

SHORT ADJOURNMENT