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

OPERATION FLAXTON
HEARING NO: 18/0003

DAY 16 – MONDAY 19 NOVEMBER 2018
(DURATION: 1HR 55MINS)

LEGEND

PO Presiding Officer – ALAN MACSPORRAN QC
CA Counsel Assisting – GLEN RICE QC
INST Instructing – REBECCA DENNING
HRO Hearing Room Orderly – AMY SMITH
W Witness – DR JOHN WAKEFIELD
LR Legal Representative – MR CHRISTOPHER MURDOCH SC
INST Legal Instructing - MS PATRICIA CLOHESSY

PO This is a hearing of the Crime and Corruption Commission conducted under section 176 and section 177(2)(c)(ii) of the *Crime and Corruption Act 2001*.

Before I commence with the formalities of the hearing itself, there are some housekeeping matters that I need to attend to.

In terms of evacuation procedures, in the unlikely event that the building fire alarm activates, we request that you remain seated and await instructions. If evacuation is required, please follow the directions of the fire wardens, who you will be able to identify by their red or yellow safety hat. You will be directed to the fire stairs outside this room and then to the evacuation point outside the building. If you have any mobility concerns, please identify those to the fire warden, and assistance will be provided to you. Signs outlining the evacuation procedures have been placed in the public gallery today.

The Commission has published a number of practice guidelines on our website, and I am assuming for the purposes of this hearing that you all had access to those and are familiar with them.

In addition to these, I ask that you please observe the rules that were displayed as you walked in, but, in particular, can you please follow the direction of CCC staff and Queensland Police Officers present.

Do not disturb or interrupt the hearing and please switch your mobile phones off or to silent or any electronic devices you have to silent, and refrain from moving around the room while the hearing is in session.

Everyone should also be aware that although we are not live streaming the proceedings today, everything that happens will be recorded throughout the proceedings and the transcript will be published on our website most likely tomorrow.

The Commission resolved on 19 March 2018 to hold public hearings in relation to Taskforce Flaxton, which is conducted under the Commission's corruption function. The first phase of the hearings commenced on 14 May this year and ran for 13 days. Thirty witnesses gave evidence as part of an examination of corruption and corruption risks in Queensland Corrective Services facilities.

The second phase of the hearings, which commenced on 28 and 29 August last and is continuing today, will focus on matters pertaining to reforms with a view to better preventing, detecting and dealing with corrupt conduct within corrective services facilities.

As Chairperson of the Commission, I will conduct the public hearings as the Presiding Officer, and Mr Glenn RICE QC has been appointed as counsel assisting the inquiry.

I nominate as the hearing room orderly Ms Amy SMITH to administer an oath or affirmation or any other solemn declaration to any witness appearing at the hearings.

Pursuant to sections 5 and 5C of the *Recording of Evidence Act 1962*, I direct that any evidence to be given and any ruling, direction or other matter be recorded by recording equipment and that Ms Kathy ROBERTSON and Ms Roxane LANE will be the recorders for the purposes of today's hearing.

It is proposed that at the end of today's proceedings, potentially, any exhibits tendered during the course of the proceedings will be published on the Crime and Corruption Commission's website. Some exhibits have had personal information redacted. If there are any concerns about the publication of any of the exhibits or part thereof, the witness or their legal representative should make a submission before the end of the day in relation to that matter so it can be considered and attended to.

As I said before, it is anticipated that a transcript of today's proceedings and any exhibits will be available on the Crime and Corruption Commission's website tomorrow.

At the original hearing in May and the resumed hearing in late August, I made a brief observation concerning the purpose of these proceedings. For those of you who are not familiar with this observation, I will make it again, so it's clear.

This public hearing is not about laying blame or examining individual cases of allegedly corrupt conduct. These hearings are more concerned with identifying systemic deficiencies in the system of governance surrounding the operation of corrective services facilities. The purpose of these hearings is to establish what works and what does not work and to ultimately make a series of recommendations in a public report, which will promote transparency, integrity and accountability, to ensure that a world's best practice model of operations of Queensland Corrective Services is achieved, to guarantee the safety and welfare of corrective services officers and prisoners alike.

If any person or organisation has information about specific instances of alleged corrupt conduct, I urge them to come forward to the CCC confidentially to report such behaviour, and it will be assessed and, if necessary, fully investigated in the usual way.

Mr RICE, are you in a position to proceed?

CA Yes, Commissioner. It is proposed to call two witnesses today to complete the public hearings. To begin with, I call Dr John WAKEFIELD.

PO Dr WAKEFIELD, I notice, is currently present.

Mr MURDOCH, I probably should get you to announce your appearance for the record again.

LR Yes. May it please the Commissioner. I appear with Ms CLOHESSY for the Department of Corrective Services, instructed by Crown Law.

PO Thank you.

You took an oath last time, doctor?

W Yes.

PO I think we'll have you sworn in again, just to make sure. It is a formality.

John WAKEFIELD, sworn:

PO Yes, Mr RICE.

CA Thank you.

You are Dr John WAKEFIELD?

W Correct.

CA Dr WAKEFIELD, you last gave evidence in these hearings on 30 May this year. Did you subsequently receive another notice to attend today?

W I did.

CA Could I show you this notice, please.

W Thank you.

CA Is that a copy of the notice that you received?

W Yes.

CA I tender that.

PO I'll make that Exhibit 104.

ADMITTED AND MARKED EXHIBIT 104

CA When you were here in late May, you identified that you were the chairperson of a committee described as the Offender Health Services Steering Committee Alliance, whose acronym is OHSSCA; is that correct?

W That's correct.

CA There is, I think, a brief fact sheet published on the Department of Health website, which refers to the work of that committee. Can I show you this.

W Thank you.

CA Do you recognise that as a copy of the fact sheet entitled Offender Health Services published on the department's website?

W Yes, I do.

CA I tender that.

PO Exhibit 105.

ADMITTED AND MARKED EXHIBIT 105

CA I just want you to have that in front of you, doctor.

W I have one, thanks, yes.

CA The fact sheet may be a bit historical in as much as it refers in the middle of the page to the fact that OHSSCA will be established and chaired by you. That has in fact now occurred; correct?

W That's correct.

CA And it refers to the inclusion in the committee of a range of key stakeholders, including hospital and health services, QCS, unions, consumer organisations and other oversight bodies. Has that occurred?

W That's correct. That committee has been meeting through this year.

CA You told us on the last occasion that PricewaterhouseCoopers had been engaged to conduct the review referred to in the fact sheet, in collaboration, I take it, with the committee; is that so?

W That's right. We felt, as a committee, that it was appropriate to retain an external party to undertake the review, but in consultation - steered by the committee.

CA Recently I think PricewaterhouseCoopers was able to furnish a report to the Department of Health?

W That's correct.

CA Can I show you this.

W Thank you.

CA Is that a copy of the report arising from the review?

W It is.

CA It contains, does it not, a range of recommendations on a number of issues; correct?

W Yes.

CA Having regard to the breadth of the report, I take it that the department and more widely the government need some time to digest the report and the range of recommendations made within it?

W That's correct. The report contains findings and recommendations, and those are subject to consideration by cabinet and government.

CA Having regard to that, the report itself is not presently available for public dissemination; am I right?

W That's correct.

CA I nonetheless tender that, Commissioner, on the basis that it not be

published.

PO All right. I'll make that Exhibit 106 and I will direct that that Exhibit 106 remain confidential until we publish our report into this inquiry later this year.

ADMITTED AND MARKED EXHIBIT 106

CA Are you at liberty to talk, Dr WAKEFIELD, about the process of the review and some of the issues that may have emerged in the course of consideration of its task?

W Indeed. I am at liberty to talk about general issues from the review and general findings.

CA Can you talk firstly about the method of the review and how the reviewer, PricewaterhouseCoopers, interacted with your committee?

W The committee oversaw the establishment of terms of reference and specifications essentially for the review, which was subject to a tender process and PwC were successful.

From that point, the committee provided guidance to PwC and a touchpoint along the process of conducting the review in terms of the early scoping work, early consultation, the work of understanding a literature review and comparative information from other jurisdictions. And then very much to coordinate the review, particularly visits to every correctional facility, we felt it was really important that because each correction facility is unique, really, and the contexts are different, they had to have boots on the ground in every place, and we provided support for that and also consumer involvement around that. Then the report was finalised and again presented to the committee in its pre-final stage.

CA The fact sheet refers, by way of background, to the devolution of offender health service delivery in 2012. You referred to that last time in your evidence. It goes on to outline that, arising from that, there was no retention of system-level governance, with the result that there was limited system-level strategic response to various challenges that were being faced. I take it that was one of the themes or one of the impetuses of the review?

W Just in terms of triggers for the review, why did we establish the committee, why did we undertake such a review, there were several things that, I suppose, conspired, in a way, to us being clear -- that is, the department -- that we needed to take a look at offender health services. They included concerns raised from the OHO, the Office of the Health Ombudsman. There had been a fairly significant increase in complaints over the course of the prior year, which they were working with each health service to oversee, but I think they felt that a broader review was necessary, and also workforce issues and also the outcome of the Auditor-General's report into the private prison sector, which had been conducted previously. So there were several things that led to, I think, pressure -- it was clear that these are services under pressure and it was time for us to have a clear view.

Because since 2012 there was no central footprint for offender health

services in Queensland in the Department of Health, we also lacked visibility and really any data to help us understand what was going on without doing such a review.

CA One of the features of method, I think, was that there was some fairly extensive consumer consultation; was that the case?

W That's correct. Over the past few years, we've been very focused on making sure that consumers are at the centre of our service design and its development and evaluation across the board.

CA When we speak of "consumers", we're speaking of inmates of the various correctional centres?

W In this case, with the offender health services review, particularly we're speaking about inmates, prisoners, yes.

CA How was that consultation undertaken?

W We actually contracted some work to Health Consumers Queensland. They were represented on our committee, and they are the sort of pre-eminent consumer advisory body and have expertise in being able to elicit consumer feedback.

They undertook a process of visiting corrections facilities and sitting down with - I think they had 17 different group sessions at seven sites and interviewed, I think, over 80 consumers, or offenders. As a consequence of those focus groups, if you like, they elicited a number of themes that prisoners had in terms of their experience of health care.

CA Once again, on the Department of Health website there is a fact sheet concerning the undertaking of this consultation and a brief synopsis of the outcome; am I right?

W Correct.

CA Can I show you this fact sheet.

W Thank you.

CA Is that a copy of the fact sheet referring to the work undertaken by Health Consumers Queensland to undertake this type of consultation?

W That's correct. There was an excellent report produced by them. We elected to get the message out in a more concise way. We elected, with their agreement, to summarise that into this infographic, information sheet.

CA Would you care, as briefly or as lengthily as you wish, to just address some comments to each of those themes?

W Just in terms of an opening comment, as I said, I think this was an excellent piece of work conducted by Health Consumers Queensland and really got to the heart of the key issues. There were no surprises in here, but it actually lined up very much with, I suppose, information that we had from other sources. Particularly it gave us some perspectives from

consumers about how we could do better, so for that reason I think it was incredibly important.

There were five key themes that came out of this piece of work. The first one was communication and culture. I won't read all of these that are in the report, but I think what's really important is that prisoners felt that, at times, they were subject to, I suppose, prejudice, particularly in relation to, for example, drug-seeking. At times some prisoners felt that health staff tarred them all with the same brush, if I can put it that way, in terms of assuming that any complaint that they had, any pain, was subject to them seeking medication. Their request was that their requests for assistance should be considered genuine in the first instance.

The other comment that was made was about health staff and corrections officers working better together and treating each other with respect. One of the suggestions that was made was that health staff made themselves available to attend the prisoner advisory committee meetings, which occur at every corrections facility, to help improve communication. So there was a number of - and I might say that, in summary, these were - there were obviously positive comments as well. These are reflective of some of the experiences.

The second area, and one that we're particularly focused on, is requests from prisoners for medical appointments or health care appointments. One of the things that surprised us but also, I guess, validated concerns was that, more often than not, when a prisoner requests an appointment or to see the doctor or nurse, they're not actually given any feedback as to whether that has been accepted, whether it has been rejected, how long they will have to wait - a day, a week, a month - and so they're really left in the dark.

CA Is there an issue about timeliness of response to such a request?

W I think there were two issues. One was getting feedback about the fact that if they would be seen and approximately when that would be, and the second one is obviously the timeliness of the service.

They also had suggestions about increasing clinic times to 24 hours a day. This is not the case in many prisons. And of course they are not free to access after-hours services as the general population are. They also asked for improved access to allied health providers -- physiotherapists, podiatry, dietitians, et cetera. The gist of that was really about access, both timeliness, scope of services that they could access, but also just being told, given information as to when that would occur.

The third area was medications management. Traditionally prisoners are not allowed to keep any medication, so they have to line up in a line. If they're on three-times-a-day medication, they line up three times a day. They felt also that often medication was changed from when they entered prison or when they changed prisons, without any good explanations.

A particular, very simple thing that was raised, which I think certainly we have to take note of, is just not being able to get Panadol or ibuprofen just as you and I would do if we had a headache or some pain. They actually can't do that without a medical prescription. Again, they suggested that access to that would make it a lot easier for them.

The fourth area was specifically about oral health. There were concerns about oral health only being provided to patients that were longer term and not to short-term or remand prisoners; healthy food options, dental floss, et cetera, which is not allowed in there; ability to provide water in drink machines instead of just sugary drinks. Again, these are prisoner recommendations about access to healthier drinks and oral care that they can do for themselves, not just professional services.

Finally, but not unimportantly, mental health. They particularly raised issues about overcrowding and particularly double-bunking in cells where, really, the consequence of never having any alone time for some is significant in terms of adverse psychological consequences.

So whilst mental health services into prisons are particularly focused on serious mental illness, psychological distress, mental wellness and all the issues that are really important around stress and anxiety are more difficult to access in prison, and they were really keen to be able to access greater mental wellness programs.

Finally, the opioid substitution. Whilst that's available in one or two prisons and it is subject to a broader roll-out, the ability to actually get opioid substitution, if they're addicted to illicit substances, is something that they desperately want.

CA You mentioned earlier that one of the drivers for the review was an increase in the number of complaints by prisoners to the Health Ombudsman.

W Yes.

CA Are you aware of whether there was any correlation between the breakdown of the content of those complaints with the kind of feedback you got from this consultation that you have been referring to?

W In the, I think, over 1,000 complaints received by the Health Ombudsman in the prior year or thereabouts, the top three issues from the Health Ombudsman's analysis included: culture and communication; the second one was access to services; and the third one was medications management. Those three complaints categories really mapped particularly well, I think, to the five categories elicited by Health Consumers Queensland.

CA The information sheet concerning the establishment of OHSSCA refers to offender health services being under significant pressure. We might talk a little bit about what some of those pressures are. Before doing that, would you mind just recapping for us on the nature of health services that offender health services provides?

W Certainly. Generally speaking, offender health services captures what we call primary health-type services, the sorts of services that you would get from a GP. Those services are delivered in the corrections facility in some kind of physical infrastructure, so an area with a back-of-house function and sort of reception areas and maybe some assessment rooms where patients can essentially be assessed and treated as necessary. The types of people that provide those services are generally nurses. There are

medical staff that visit, but the predominant model is nursing care. In addition to that, visiting the correction facility there are some specialised services. They include, for example, mental health, so specialist mental health, some outpatient services and oral health.

In the privately operated prisons, it is a similar model, although the primary health care, the staff that we would have as offender health care services working in those prisons, are contracted privately by the prison operator. Mental health and oral health care are still provided by us and go into those two corrections facilities.

Where there is a need to have a consultation with a specialist, and particularly if specialist surgery is required or investigations, then prisoners have to leave the prison and attend either the local hospital or a specialist prison hospital service, such as the one located at the Princess Alexandra Hospital.

CA That raises the issue of the availability of escorts, presumably?

W It's considerable -- in terms of the Princess Alexandra Hospital, obviously all prisoners need to be escorted, but within the PA unit, that's preferred by the corrections because it's established as a secure unit and the escorts can then leave and go back to duty.

CA Is that where all hospitalisations of prisoners take place?

W No, not at all. Outside really what would be the south-east corner, most of the hospitalisations do not occur at the PA; they occur at their local hospital, for example Townsville. In that scenario, prisoners are treated in a regular hospital. The burden on corrections, then, to provide round-the-clock restraint and supervision is significant. But, of course, it's a long way to go from Townsville to Brisbane, depending on what the circumstances are. So unless it's something that requires a significant length of stay or a level of service that can't be provided at a major regional hospital, the vast majority of those occur outside of the PA unit.

CA OHSSCA was established on the footing that offender health services was under significant pressure. Before we turn to some of the themes that emerged from the review itself, perhaps we could just talk about some of those pressures.

W Sure.

CA Some are perhaps alluded to on the information sheet itself, and the first thing I was going to ask you about was the nature of the general health of the prisoner cohort by comparison to the general population.

W Prisoners, by their nature, offenders in prisons or corrective services facilities, are a particularly vulnerable group. By and large, they're not representative of normal society. They have significantly higher rates of mental illness. And, for example, there's also a significant rate, which is hard to establish, of intellectual and cognitive impairment. Some of that is related to behaviours, drug use and so on, and some of it is congenital. For example, foetal alcohol syndrome is considered to be fairly prevalent in the prison population.

Illicit drug use is significant and, in some studies, is as high as 60 or 70 per cent for arrests, for example, for drug use in the last week. But certainly injecting drug use is a significant problem. Serious illicit drug use, again, is a problem in at least a third of the population.

Because of these risky behaviours, prisoners tend to have high rates of communicable diseases. For example, hepatitis C, which is a serious blood-borne virus contracted through needle sharing and also sexual activity, is present in around 30 per cent, or one-third, of all prisoners. If left untreated, that often leads to liver failure and liver cancer.

In addition to that, rates of chronic disease are deemed to be significant. Obviously there is a significant element of homelessness with some of the prisoner population. To that end, they grow older more quickly. So a 50-year-old or a 60-year-old in a prison population is much more akin to a person in the general population that's 10 or 20 years older.

Finally, perhaps, the starkest figure is that indigenous people are significantly over-represented, 10 or 11 times the general population. So a third of the prisoners are indigenous.

CA Do they have particular health issues?

W Indigenous prisoners have all of those other risks that I have outlined, but also, I think, the young indigenous are particularly vulnerable psychologically -- suicide and the cultural issues about being removed from community and so on.

CA You've touched on the subject of mental health. There has been some evidence given in these hearings, not from a medical provider, that perhaps up to half of the prison population may enter correctional centres with some form of cognitive impairment. Does that strike a chord with you?

W Yes, it does. I think in terms of cognitive impairment, both acquired through drug use but also congenital, as I indicated before, foetal alcohol syndrome, for example, and other congenital conditions, being born with some level of intellectual impairment, does render you significantly more likely to get on the wrong side of the law and end up in prison.

It's hard for me to comment on the 50 per cent. There are studies around, but certainly it's thought to be a significant proportion. The challenge is that those people don't fare particularly well in prison and that they often are vulnerable to being victimised, et cetera. So it is a problem. Again, disability-type services -- people with cognitive and intellectual impairment are not necessarily assisted by mental health services.

CA There is a prisoners mental health service, is there not?

W There is a prisoner mental health service, correct.

CA How is it constituted and what work does it do?

W In terms of mental health - and this is not always understood, I think, in terms of what we mean when we say "mental health". The offender mental health services really mirror the mental health service provided by

the public hospital system to the general community. That really relates to severe, significant mental illness.

CA Diagnosed mental illness?

W Diagnosed mental illness, for example, schizophrenia, severe depression, bipolar and some other types of significant mental illness which require specialist mental health input, psychiatrists, often require anti-psychotic medication and so on. That is the remit of hospital mental health services to the general community and also to the prison service.

The overwhelming what I would call mental wellness, psychological wellness and things that fall under the remit of stress, anxiety, minor depression, which would normally be treated in the primary care environment, not in the mental health service per se, are particularly not well served in a prison population, because the prison mental health service doesn't have that remit and that's left to the primary health care service in the prison itself, so the nurses on the ground.

The nurses and the medical people do as good a job as they can, but really I think they don't necessarily get the same access to psychological support and counselling and the sorts of services that target people particularly with anxiety and depression.

CA How would that be accessed by persons outside of prisons?

W The general community, of course, can access Medicare. They can access Medicare services in relation to GPs particularly, but also the Commonwealth Government provides Medicare reimbursement for psychological services. For example, there's a program where community members can access, I think, up to 10 sessions with a psychologist to manage anxiety, to manage depression, cognitive behavioural therapy and so on. That is not accessible to prisoners.

CA It may be a very basic thing, but could you tell us, does Medicare extend to prisoners?

W No. The Commonwealth Government, I'm advised, has taken a position that prisoners under corrective services are not eligible for Medicare and are the responsibility of state governments and state health systems. As a consequence of that, the funding of prison health services falls totally on the state governments.

CA Can we talk a little bit about infrastructure. You've already touched on it, I think, by identifying that within a given correctional centre there will be some assessment facility.

W Yes.

CA Typically what would that consist of? Is there a typical answer to that?

W Well, they're all different and, again, I haven't visited all of them. I've certainly been on the ground, and what I've observed, and I understand certainly this is similar across all of the facilities, is that they were built some 20 or 30 years ago; they're not fit for purpose; there has not really been any investment in that capital infrastructure. The design and the size

are such that, particularly with the tremendous growth in prison population, even if you can get additional clinical staff to work there, there's just insufficient space and facilities.

In addition, diagnostic facilities, X-rays and so on, are not something that you generally find in prisons. They have had to adapt, and because they're still on paper, there are still lots of filing cabinets, they're not an environment for today's world; they're not fit for purpose.

CA This is a very general question, and answer it if you can, but are prisoners able to consult with the degree of privacy that we would associate with consulting a medical practitioner?

W That came up in the prisoner feedback. Certainly there are consultation rooms, and, under normal circumstances, there is an ability to have privacy of interactions. However, certainly what we have been advised is that prisoners do often have to line up for receiving medications and so on, and because of some of those infrastructure concerns, privacy is an issue, both physical privacy and obviously verbal, being able to talk without being overheard.

That's one thing, but the most significant issue that our staff are now facing and the prisoners are facing is that because of the significant overcrowding, corrections earlier this year instituted rolling lockdowns of staff, so essentially locking up half the prison population, for example, for half the day.

That's a game changer for the clinical staff, because ordinarily giving insulin injections, giving medications out, the patients come and queue up, and that's quite efficient; now the nurse has to go on the walk with a corrections officer and actually hand those things, including giving injections, through the door of a cell.

CA Because the prisoners are not able to visit the on-site facility?

W What we're hearing -- and it's hard to get good data on this, but certainly what we're hearing is that the time taken to conduct one of those rounds is double. So if it takes four hours to do a normal medication round, it's now taking eight hours. You can imagine the safety and privacy concerns of having to give medication out through a locked door, for example insulin, and so we're also finding that sometimes those just don't occur. They run out of time or there's some other incident, which means that prisoners don't get that medication.

Privacy-wise, going back to your original point, of course, how do you provide privacy in that sort of environment? The other concerning issue about that is a significant safety issue. When the nurse goes on that round, they don't have the information with them in terms of the medication, because it's kept in the prisoner files, and they can't take all those with them, so there are also serious risks of misidentification, giving the wrong patient the wrong medication, and it's creating an enormous amount of stress on the clinicians as well as on the prisoners.

CA You mentioned earlier restrictions on prisoners holding medication which they regularly take.

W Yes.

CA How is that situation managed? You and I would have a packet of tablets and take as prescribed, but how is it managed for prisoners?

W Speaking as a clinician, I can understand that in the past -- some medications are dangerous and some medications are tradeable, and I can well and truly understand that there are security and safety implications to having prisoners hold their own medications and self-medicate. It appears that there is sort of a blanket application of that across the board, which clearly has a consequence in terms of prisoner access to their medications but also the efficiency and the ability of clinical staff to be able to provide that.

In the review, and certainly looking at other jurisdictions, there's no easy solution to that, but there are other contemporary services, New South Wales being one, and there are some international jurisdictions, that have innovated significantly in the medications area. The sorts of innovations that we're talking about include, first of all, having a sort of self-service dispenser machine, where again, certainly for prisoners that are fairly stable on medication and excluding opiate-type painkillers, they're able, essentially through their ID, to check in and get medication automatically without a human being needing to dispense it.

There are also trials, as I understand it, of certain prisoners being able to hold supplies of their own medication and self-administer. So I think there are opportunities, certainly for the right prisoners in the right settings, for us to really look to try and reform some of the medication practices. There's always risk, but I think, again, it's about sensibly trading off those risks.

CA Absent measures of that kind, could you describe what's involved in providing medication to prisoners who can't, for various reasons, hold their own medication?

W There's a significant amount of work upfront in determining the medication that a prisoner is on, particularly at transition points, points of entry into the system, where information flows are not necessarily very good. We've heard prisoners often say that they don't get prescribed what they came in on or they're missing that.

At the back of house of the clinic, usually medications obviously come into the corrections facility, but it's the nurses who generally have to take those medications off the doctor's prescription and they supply that. They don't prescribe per se, but they collect the medication from the shelf, a bit like a pharmacist would, and get the pills, and then as the patient comes up, they will check them off, check what they should be getting and then give them those pills.

CA That's if the prisoners are able to visit the facility?

W If the prisoners are able to visit. Otherwise, they package that up and then they go walk-about, again without all the medical records that would allow them to really appropriately supply that to a patient through a locked door. So there are significant safety issues and significant inefficiency in having nurses essentially do work which ordinarily could

be done outside the corrections facility.

Again, with the right information systems in place, it's possible outside the facility to have a patient's medication packaged up and then provided to the corrections facility, so that literally Mr Smith's medication for today is packaged in a little plastic pack, with those pills already in there. So all of that work doesn't have to be done in the corrections facility. It's done at the pharmacist before it arrives at corrections, so both the space required to do that in the corrections facility would be avoided, but also all of that time for the nurse on the ground trying to do it.

CA How resource intensive is it, because some of these centres have 1,000-plus inmates and a good proportion of them are on some kind of medication, are they not?

W That's correct. Again, I'd have to check the figures on this, but I think it's something like half of the prisoners are on medication. Given that those medications would be given every day and sometimes twice a day or three times a day, a significant amount of the work of health staff in the prison is in relation to medications management.

CA Is it what the nurses would associate with a professional function?

W Administration of medicines is certainly part of the scope of practice and function of a nurse. I think what is not usually the function of a nurse is the processing, is the work done that would normally be done by a pharmacist and pharmacy technicians to literally take boxes of medications off the shelf, open them up and get one pill. So if a patient is on five medications, for each time they turn up to the clinic, they actually have to pull those medicines together and then physically give it to the person. It's an enormous amount of work. That duty is not usually a duty for them, and it's really a waste of their clinical capability that could be applied to patient care.

CA You mentioned the impact of lockdown. That means that the nurses actually have to go and do rounds, so to speak.

W Yes.

CA Are there other implications for health service delivery of the kind of -- well, the fact sheet doesn't use the word "overcrowding". It does refer to a 40 per cent increase in prisoner numbers. What impacts does that kind of an increase have on service delivery?

W If I perhaps start off with the impact on staff, certainly from the literature, I think the review allowed us to hear the voice of staff on the ground in every facility, and certainly what they said matches to the literature on this. The impact of overcrowding on staff really causes psychiatric disorder in staff, and there's a number of studies that show this.

Essentially the environment within which they work becomes obviously significantly more stressful, the frustration of not being able to do their job properly, and particularly the sort of example I gave you before, really trying to do a medication round through locked cell doors is very challenging for them. Fundamentally I think it removes their sense of being able to do worthwhile work and do what they come to work to do,

which is to give the best health care. It reduces health care to really the most reactive nature, literally just doing the pill round, I think, and that's probably about it.

The consequence of that is significant psychological distress for staff, and the consequence of that is that staff often then leave, and we resort to -- that's harder on those that remain. The other thing that we could see in this review is that the use of agency labour to fill holes is significantly increasing. The issue with that is that it's much more costly, but also agency labour is the least connected and unlikely to really be either expert in offender health or genuinely committed to creating a culture where people want to work. So I think overall it's significantly corrosive to the sort of culture and environment of care where health can improve.

CA We have spoken there about the impact on health providers, particularly nurses. What about impact of the increased prisoner numbers on service delivery generally?

W What's happening is that really the cost of service delivery is going up and the outcomes of service delivery or certainly the amount of services that are being able to be delivered is probably going down, so the ability to care for prisoners when there are so many and the turnover is so high, and particularly with overcrowding-

CA I'm sorry to interrupt. Is there an access issue?

W There is an access issue.

CA Is that accentuated by this increase in prisoner numbers?

W Yes, because particularly the local facilities are just not capable of coping with the number of prisoners or the number of staff that you have to have on the ground to do that. There are some significant consequences to prisoners as well in terms of overcrowding.

CA Are there medical staff, that is to say doctors, assigned to each centre, who work at these facilities that you've described?

W There are visiting medical officers that are on staff at the corrections facilities, but relative to nursing care, their numbers are small. Traditionally they'll come and do a sessional time, see patients that they need to see, but also a lot of that is administrative medication, so sorting out prescriptions and writing prescriptions.

CA You used the words "visiting medical officer". Do we take it that that is what they do, come from outside and visit for a session? Can you describe it?

W For the most part, they're part time, yes. I think there are a couple full-time doctors, but for the most part they're part time.

CA How are any emergent circumstances dealt with, then, within the correctional setting, if medical staff, particularly doctors, are not necessarily present?

W As I indicated before, in the case of an emergency, if it's during clinic

hours and they can handle it in the clinic, then they'll manage it internally. If either it's during hours and they can't handle it, so it's serious and they need investigations that they can't do at the clinic, or it's after hours and there's no clinical assessment facility there, then that prisoner usually will be transported to the closest emergency department in a hospital.

CA When you gave evidence the last time, there was a point of some emphasis, I think it's fair to say, your mention of the absence of any electronic prisoner record.

W Yes.

CA Was that a subject that was considered in the course of this review, the implications of that?

W Absolutely. The review was particularly looking at -- well, one aspect of the review was looking at the system, the strategy for offender health services, the system leadership, where it was going, what were the key components that needed to be in place to help it achieve its objectives.

The current system is paper based. The West Moreton Health Service manages prisoner records. Essentially they are the repository for the prisoner record. When a prisoner comes into a corrections facility, that record, if it exists, is called for and it makes its way to the prison. That can take a few days. Or if they've not been in prison before, one is created.

The difficulty with that is, as we've already heard, prisoners move. There are reception prisons and placement prisons. Prisoners move for health care both within their local health service but across health services. So the need for information to be rapidly accessible by numerous people within the prison health system and the hospital system but also when they leave prison, to make sure that that continuity of care, which is so important, is continued, is just not there.

Already committed to, already having received funding, there is a project to establish an electronic health record for prisoner health, such that all of that work -- such that that information goes with the prisoner, wherever they are and is available at the-

CA In a timely way?

W In real time. And, importantly, that information is able to be accessed in the community as well, so that again there is continuity. We know how important it is, particularly at discharge from a prison, how tenuous that person is at that point for a few weeks and what the trajectory is. I think good health care, wrap-around health and social care at that point, really prevents adverse consequences for that person's family and for that person as well.

CA Until an electronic prisoner record system is developed, can we take an example, say a male in the south-east corner. A very typical progression would be from the watch-house to Brisbane Correctional Centre as a reception centre?

W Correct.

CA From there to a placement centre?

W Yes.

CA What steps would you expect to be taken at each of those junctures to create or access a prisoner's medical records?

W At each one of those places, there's a need for a clinical person to do an assessment. So the person arrives and they need an assessment. They will probably need medications prescribed. They will probably need some kind of treatment plan, for those that require that. Not all of them do, but a majority do. So that record is created, and it takes a lot of time. Of course, if information is required from the health practitioners in general practice, in the hospital system, that has to be all collected manually, phone calls and so on. It's very time consuming.

In a flash, that person can be transferred from the watch-house to the reception centre, and sometimes those physical records don't go, for whatever reason. Sometimes they do. And then another assessment has to occur. I understand it's quite common, particularly when prisoners move, that those records sort of lag behind the prisoner. Bear in mind that the physical record is maintained at West Moreton. Particularly if they've been here before, there's a significant lag of time, and that lag of time causes significant safety issues for the patient and gross inefficiency.

CA There are two aspects - you've just mentioned them, I guess - the efficiency aspect but also the very basic matter of proper health care?

W Yes, the wrong medications being given, medications not being given when they should be, particularly if the patient does not know the name of the medication, or whatever. They can really suffer. Some of those medications are very important, and if they're stopped, even for a short period of time, there can be significant consequences -- insulin, for example, as well as some of the cardiac medications. There can be significant consequences.

CA Is there an impact on prisoner mental wellbeing through the inefficiencies that you've described? Presumably there's a physical aspect, too, of whether they are or aren't getting the medications that their bodies require. Is there an impact on a prisoner's wellbeing with that kind of inefficiency in existence?

W All we can really draw on there, I think, is -- I mean, the effects of overcrowding are significant, and I've already covered those. I think the effects of the frustration of not being able to maintain medications that you're on or to feel as though your health deteriorates because of the wrong information or lack of information came through significantly in the Health Consumers Queensland work. So really that's probably the best bet to go on, and obviously it's a major theme in the Health Ombudsman's complaints.

CA Perhaps we could turn to some of the themes that arose from consultation in the course of the review. There were a number of themes, were there not, commencing with the heading of relationships and governance? The governance, I think, is a reference to the decentralisation back in 2012 and the devolution of responsibility for the various hospital and health

services, with the gap in strategic response that even the information sheet referred to. Are you able to say how the review found that that devolved model impacted on attempts to meet the various challenges that we've spoken about?

W Certainly in general terms, the absence of system leadership was found to be a significant contributor not so much to the problems but to the ability to address those and get ahead of the issues. Since 2012, these offender health services are looked after by eight independent hospital and health services. In the funding agreement between the Department of Health and each of those health services, really beyond the transaction of dollars, there are no measures that capture the outcomes of offender health.

CA What kinds of measures would be helpful to know about?

W At a very base level, basic activity, so what sort of model of care is provided, what sort of staffing is there, what sort of key performance indicators are there, which really map to the strategic intent of offender health services? For example, assessments conducted within the first 24 hours. Usually targets on process indicators are really important to drive behaviours, the percentage of assessments conducted within the first 24 hours, things like communicable diseases screens and hepatitis C commencements, and so on, so there's a range of indicators that would help to drive behaviour of health services.

I think the absence of a central component to the system means that offender health services are sort of buried in each of the local hospital and health services. They comprise a very small proportion of their daily activity and their work and they've got plenty of challenges to manage demand in the general community, and I think without those measures shining a light on it, really, the staff just have to get on with it and do the best job they can, which they do, but there is no clear strategic plan which would guide what we're trying to achieve with the prisoner population whilst they're in a corrections facility. There is so much that we could achieve to assist to improve their health.

CA You used the word "reactive" a little while ago in reference to some of the functions performed by nursing staff. Can I ask you to what extent that description "reactive" might apply to other aspects of offender health services delivery?

W Again, I think that to a large extent -- and the review found this -- by and large, the staff in these services are highly motivated. They want to do a good job. They increasingly are finding it more and more difficult to do even the basic level of primary health care. As I said before, particularly with the overcrowding, the rolling lockdowns was a point in time where that really significantly disrupted the current model, and I think now the model is just really reactive to that circumstance. And it's much bigger than health, obviously. If they can't access the other types of remediation, physical exercise, job-ready programs and so on, that's a serious consequence for prisoners.

So there's the consequence of overcrowding that has made health become even more reactive. What we're talking about with central governance, though, is the ability to make strategic plans for this work, to define things like how we're going to improve prisoners' health, chronic disease,

eradicate hepatitis C, manage opioid addiction through opioid substitution, safe sex, needle exchanges, all that sort of work, which is all controversial, but the ability to take a step back and say, well, our job is not just to reactively provide primary health care; our job is to take this vulnerable group whilst they're basically captive and work with them, certainly those that want to do that, work with them to really optimise their health.

That doesn't happen in sort of tactical health services without a strategic drive and leadership. So whether it's the informatics and the information management, whether it's training and a pipeline for staff, whether it's policy, whether it's funding arrangements, whether it's capital infrastructure, whether it's research, and education, all of those things just fall by the wayside if all that's happening is these survival tactics on the ground. I think that's what we're really seeing, and that's not going to change unless we change it.

CA In whatever form the change might take, is it to be hoped that the more reactive style of operations might be, in due course, replaced by something more strategic?

W I don't want to suggest in any way that the reactive care is not necessary. It's the bottom level, if you like, of care. You can't take it away. It's necessary. It's necessary but not sufficient.

The hope of certainly the staff on the ground and their leaders is that we will invest in them and work collaboratively and collectively with them, not as a command and control, but work with them -- they often have the ideas as well -- to redesign the way care is delivered on the ground, with a focus on making sure that they are working to the top of their practice, that we give them the tools, that we minimise some of the low-value work that's happening and that we innovate around that and help them or work with them to do that.

When I say "invest", investment will be required, but I think if we can eliminate a lot of this inefficiency, as well, because of overcrowding, we'll get much more bang for buck out of the resources that we currently have. I think that's really the hope of the staff on the ground, if I can again speak for them.

CA In terms of relationships, if we accept that the Department of Health, perhaps since 2012, has not been exercising a system manager role to the extent, on one view, as desirable, how have necessary relationships been managed between the Department of Health and QCS?

W Individual memoranda of understanding, I understand, have been developed with a health service and corrections at whatever level which are really context specific to the particular environment they're in. I guess from corrections' perspective, that means that there is a lot of variation and that there is probably a lot of work in generating and managing the relationships around those agreements. Without a footprint and without a go-to in the Department of Health, really, the ability to -- not to standardise everything but to streamline and standardise the things that really matter about characteristics of offender health services has sort of been lost. So I think from corrections' perspective, I know that certainly in the time the committee has been running, they are much happier that

we have a relationship being built at the senior levels of the organisation as well, and the plan would be, I think, for us to re-establish a state-wide memorandum of understanding and try to certainly capture a realistic initial set of agreements around clinical care and what the interface looks like.

There is no doubt that for us to achieve better health for prisoners, we have to work hand in glove with corrections. Part of that is agreeing and getting clear on paper what that relationship is, but also an important part of it is actually the relationship itself.

CA The second of the themes emerging from the report is under the heading of "Workforce" and incorporates, I think, medical staff and nursing staff. You described some of the nursing functioning earlier. Has it had an effect in some or all of the health services in terms of attracting and retaining nursing staff?

W It certainly has. In terms of nursing, first, it is a nurse-led model. What we find is that -- and this is not the same in every facility, actually, so it does vary. Some facilities actually have a pathway where they strategically grow their own. They have student placements, they have junior and senior grades of nursing, so there is a career path, and there is probably a higher degree of clinical stewardship and leadership there. In others, it's pretty flat, with just one grade of nurse.

CA A low grade or a high grade?

W Clinical nurses. So a middle grade, I suppose, would be the way to put it. And I think with no real student pathway. In addition to that, it's a pretty tough job in many respects. There are certainly opportunities for -- people do sometimes need a break, and so that ability to rotate staff through the health service into corrections and back out again, again, is another feature, I think, of a more mature service.

What we're seeing, though, as a consequence particularly of overcrowding but, as I said, the lockdowns per se, is we're seeing a lot more agency staff. So we're seeing more vacancy, more people not willing to work there and therefore greater difficulty in attracting staff. I think there's a number of solutions, some of them raised in the report.

CA To what extent are agency staff used to carry out the nursing function, do you know?

W Well, increasingly so. I don't have the exact FTE in front of me, but certainly when you look at the data on that, it's a very steep increase over the past couple of years in terms of agency.

CA Does that have any issues for continuity of care?

W Again, I don't want to demean agency nurses. It's obviously critical, and we're very grateful that they will turn up. But there's no doubt, again, the best health services that provide the best care are those that have a stable core; they understand the business; they have the relationships; they understand the procedures and protocols; they're expert in the area. It doesn't matter how good the agency nurse is, just coming in for a shift here or there, the standard of care is not the same and the commitment to

the role.

I think what that triggers is often higher costs and deteriorating outcomes, in a sense, when you have that scenario. You always need a little bit of flexible component to your workforce. I mean, that's sensible to manage variation in demand. But this is more of a systemic change that we're seeing. So really our ability to change that, I think, comes with, again, a more strategic workforce arrangement where we certainly adopt some of those strategies I was talking about before.

From a medical perspective, some of the issues that came up in consultation -- really, there's a couple of things. One is that it's not attractive and by and large they are part-time or sessional staff, so they come in and they go.

CA Why is it not attractive?

W And they're doing a lot of work which is not necessarily -- they can't work to their full scope. They're just doing sort of medication, administration-type work, but they don't have investigative tools, and so it's hard for them to diagnose, to do tests. So I think that's a challenge.

Why is it not attractive? I think it's challenging work. It's a challenging environment to work within a corrections facility. If we create the right environment and give people the tools that they need and support them and, as I said, invest, have them be able to feel as though they're achieving outcomes for prisoners, I think it will be much more attractive. I think the challenge is when it becomes very much that reactive grind. I think that's when people tend to burn out.

CA Did the review reveal anything in terms of relative resourcing, both medical and nursing, as between the various health services, anything noteworthy on that subject?

W Yes, it did. It found quite a bit of variation in the cost of offender health services between different health services. Now, at face value, that created a lot of questions, and that variation can be quite significant, a twofold variation in the cost per prisoner, which is one of the metrics that's used. However, when we explored that, when the review explored that further, it's highly contextual to the particular environment.

If I can give you an example, a reception prison like Brisbane Corrections Centre has a turnover of over 1,000 per cent per year. Essentially over 10 times the prisoner population turns over in a year. Every one of those prisoners that comes there is new, is being received and has to have the full assessment and the full check-in, and they can be gone in three days or they can be gone in a week.

CA That's at Brisbane, did you say?

W Sorry?

CA That's at Brisbane, did you say?

W That's at all reception centres, but BCC is probably the most significant one of those. Contrast that with a low-security prison or a placement

prison where the turnover might be only twice or three times the prison population per year, and once a prisoner is there, they're there, they're stable, they're on the same medication and treatment and so on. I think it becomes very obvious then why the cost is not the same and why a simple dollars per prisoner is not a good way to fund those services.

Again without being specific about the report, one of the questions that we raised that we wanted to understand was what's the cost of services and what might a funding model look like and what do other jurisdictions do. Again, one of the real challenges is, because we haven't had a clear strategy and a clear set of informatics and data, there's no offender health data repository per se, it was very hard for them to even compare the finance data that was there.

The other aspect of funding, and you'll see that on the brochure that's in the public domain, is that with the growth in prisoner numbers of 40 per cent or more between 2013 and 2017, I think, even in the last few months I understand this has now tipped to the 9,000 mark of prisoners, there has been a sort of commensurate growth, really, in FTE and prisoner funding. Again, I think we need to be cautious about those figures, for the reasons I've outlined, but there has been growth.

I think the challenge is that we don't really know what level of base funding is needed. At the time we started this, it was hard to tell. So there has been growth, but from what base is the question.

CA The third of the consultation themes was something we've touched on already, and that is the issue of access. You've spoken about the prisoner feedback through the consultation process. Were there any constraints on access to services revealed, just by virtue of difficulties that QCS might have in availability of escorts, availability of other kinds of services that have to attend, that would go with the health service delivery?

W There's a number of issues that came up in the consultation, if I can just cover off on a few of those. I think certainly there is a theme that keeps coming up about cultural issues both within the health service staff but also within the corrections staff and I think the sense that prisoners are subject to the whim of the corrections officer at the first line, when they say they need a health service, about whether that message flows through and their comments about the fact that when they make a request, they don't even know the message has been received, let alone the message actioned. It sounds very simple, but again I say that it's very corrosive. It's very anxiety and anger provoking.

There was also considerable feedback about access generally, hospital referrals, for example. The waiting times for hospital referrals impact on prisoners as well. Whilst they're categorised in the same way as the general population, again I think the lack of information causes problems.

As you indicated, resourcing restraints on escorts came up as a big issue. I just don't have objective data on that, but it certainly has come up as a big issue.

There are some health-related issues as well that came up, particularly the lack of really optimising the use of telehealth.

CA Could you explain what that is?

W Queensland has been a leader in this internationally. I think because of our distributed population and the vast distances, we have had to find a way of either bringing the patient to the clinician or bringing the clinician to the patient, and videoconferencing, video technology, has really helped, such that it's quite possible now, and this is done a lot in certain specialties, that videoconferencing can be used, so that no physical contact is necessary. Often you'll have a clinician, like a nurse or a doctor, at one end and the specialist will be in Brisbane and you'll be able to do a consultation. The local staff will be able to undertake procedures, with some guidance and so on.

My understanding -- again, I don't have detailed data on this -- is that there is a reluctance certainly at the specialist end sometimes to use telehealth. I think there are various reasons for that. There are risks that they take if they don't physically see the patient. But certainly I think that's an area that could considerably be -- it's an opportunity that we need to really focus more on, certainly for some types of interactions.

The other issues that come up in terms of access -- we've already talked about medications and offenders, really suggesting that self-administration, and so on, should be accessible to them. Needle exchange, provision of condoms -- I believe that we do neither in our system. Certainly given the prison population and the ability to spread communicable diseases whilst they're in prison, that sort of harm minimisation should be considered, I think.

Then I think there are some offender issues as well. Offenders sometimes are reluctant to say they've got particularly mental health concerns, because, as a consequence of doing so, they can be corralled into the high-risk areas, which can make them psychologically more vulnerable.

In addition, they often don't want to go to PA, because, in doing so, they'll often miss things that they actually like, family visits or other types of interventions, legal, court appearances, medical appointments, that kind of thing.

CA For various reasons, prisoners might not reveal the full nature and extent of their health issues?

W Prisoners elect also not to go a distance for medical care. They are just some of the things that came up in consultation.

CA Another of the consultation themes was service standards. We may have touched on this already. As a proposition, fragmented or at least devolved governance -- has that enabled different standards and policies to be developed and implemented at different centres, and is that a problem?

W Absolutely. Without agreement on standards, then you get variation and a lot of it. Without agreement on standards of operational hours, of staffing levels, particularly in terms of clinical specialty, for example, agreement on provision of information to offenders in a timely way when they make a request, waiting time performance, so that we're monitoring these things, really, its just impossible to know what's going on, impossible to know whether progress is being made.

If we just take the hours of operation, for example, of a particular service, unless at a system level we sit down and work out what is appropriate, should there be a standard, is it appropriate that there are two different levels, for example, in terms of 24/7 versus extended hours, then basically it will just vary locally. That is an issue, because I think then that variation is hard to manage and will often give a different outcome.

As a department, really, even with this review, the significant amount of work that has been done, without a data collection for offender health per se, it's actually very hard for us to know what's happening other than through anecdote.

CA Is that data collection that you mentioned for the purpose of providing some measurement tool of the effectiveness of service delivery?

W It would generally include -- so there's the prisoner record, which obviously is about the individual prisoner. Through appropriate use of that record, but also of relevant HR, finance and other measures, establishing such a data set would allow us to measure and monitor our strategy. If we had strategic objectives about waiting times, about hep C elimination and some processes like assessment times, for example, staff utilisation, for example -- without that data, it's hard to know whether the system is delivering on its objectives.

CA Or even where your strategic priorities lie?

W I guess so.

CA The last of the discussion themes or consultation themes was interface with QCS. Does the structured day of correctional centres impact on the working of health centres?

W Absolutely, and corrections is in the same boat. They're partners. We understand their need to manage safety and their need to manage particularly in the event of overcrowding. But, again, speaking as a clinician, the structured day for a prisoner is clearly critical in terms of their ability to get on a better track, whether it be health, access to health services, support, whether it be counselling, whether it be about work readiness, and so on. That's all very important in the context of the overall objective, which is to give people a better chance when they get back out.

I think, again, the critical element for us is obviously providing health services, which, in a sense, compete or trade off with those other elements of the structured day, and the single biggest issue with that is the rolling lockdowns, because that disturbs not just our health inputs but I think the broader remediation work for prisoners. I think the evidence is there that that then contributes to a whole lot of other risks.

CA I suppose in speaking about prisoner health, one tends to focus on the prisoners themselves, but is there a wider benefit to the community through maximising, to the extent possible, prisoner health?

W I would argue absolutely yes, and I think the evidence is there that if prisoners -- not all prisoners are motivated to do this, but a significant majority of prisoners, if they can get that sort of remediation in the prison

environment, they can come out with health gains that then flow on to both the broader community in terms of their relationships with others but also their risk of reoffending and their risk of pursuing the sorts of illicit behaviours that might have taken them there in the first place.

For example, I think particularly as a population with such risks in terms of illicit drug use, in terms of communicable diseases, hepatitis C particularly, if we're strategic in our work and a significant proportion, or even a proportion, of those prisoners manage to get stable on methadone and have a pathway, that gives them a chance of not going straight out and taking up intravenous or illicit drug use again with its associated criminal behaviour; and some coping strategies in the mental health space; Lotus Glen - hepatitis C eradication has been a fabulous story at Lotus Glen here, but we need to do that across the board. The community is so much better off for that, both in terms of not having those other risks but also in terms of the potential for not reoffending. So my opinion will be, absolutely, and I think that's backed up by a fair bit of evidence.

CA One of the aspects of the review -- correct me if I'm wrong -- was that it was to be looked at how offender health service delivery in this jurisdiction might compare around the country. Could I just ask you about a couple of things we've already touched on. First of all, the organisational model where there is a division between functions of QCS and health, health service delivery is now the responsibility of health rather than corrections. Is that a common situation around the country, do you know?

W Largely. It's a very positive thing. This goes back to, I think, 2008. When offender health came out of corrections and into health, that is a positive thing, certainly in the light of the guidance from international bodies like the World Health Organisation, for example.

I just want to refer to, if I may -- the United Nations Office on Drugs and Crime has a policy titled Good Governance for Prison Health in the 21st Century, and this comes from significant international research. Certainly there's a list of elements to that, but one of the core elements of that UN position is that prisoner health services are independent from prison administration. In Queensland, that is certainly the case now in 2018, and I think that's important.

Other Australian jurisdictions have a similar approach, with I think the exception of Victoria, where that's contained in one particular department. The benefits of that just ensure that there is that genuine independent clinical view, that clinicians are not beholden to the hierarchy of corrections and can really genuinely advocate for their patients. So I think that's a good thing about our system.

CA Is there any proposal to alter that?

W No.

CA What about, I'll call it the central governance, which perhaps has been identified as being lacking, to some degree, in Queensland.

W Yes.

CA In other states, is there a central oversight mechanism?

W Yes, there is. Again, in 2012, with those changes of devolution, that's when we lost the central governance -- well, in fact, at that point, and prior to that, it was vertically integrated, so actually the department ran the services. Once this was devolved to health services, which was quite appropriate for health services to deliver those services, but I think no longer having a central footprint in the department -- certainly, I think, the feedback from providers as well as all the stakeholders is that that is not working well and, for all the reasons we've outlined, has led to the lack of a true system leadership wherein the health of prisoners and all that goes behind that, including strategy and what we aspire to deliver and then measure, just hasn't happened. So delivery is happening on the ground, but that's not happening.

I don't think there's any debate, really, in government that we shouldn't take a central footprint again. The detail of that, what it looks like, is obviously being worked through, but I think it's not controversial to suggest that we really need to have the system take some leadership of offender health and wellness of prisoners.

CA Thank you. Thanks, Commissioner.

PO Thank you. Doctor, just one matter. You said that for the reasons you've expressed, addressing offender health in a holistic way, properly triaging, properly diagnosing, properly treating, is a huge benefit to the community more generally, for the reasons you've given. You have said that that would require an investment, and we might imply it would be a significant investment of funding, but is it the case that that upfront investment is inevitably going to save many multiples of that investment at the other end because of eliminating the extra cost to society from prisoners who are released from custody with extreme health needs, often suffering homelessness, and end up being a huge burden on the taxpayer for the rest of their lives?

W In terms of the economics of this alone, in terms of the cost-benefit analysis, I'm not an economist and I don't have those data to hand per se, but I think it wouldn't be too difficult to run, in a fairly robust and objective way, a health economic and a broader community economic benefit proposal across that and, in so doing, get a sense of where the real value propositions are for investment, and then that's a decision for government to make in terms of where it saw the most value.

Certainly the evidence that I'm aware of suggests that a holistic investment in the prison population -- and I hesitate to say it; this is not just health, but a holistic investment in the prison population will pay dividends in terms of community safety, recidivism and the health of the population.

Other jurisdictions are going through the same thing that we are, Commissioner. I note that there is a recent report -- some may have seen the Four Corners program on the British corrections system and a recent report which really highlights very similar things, and very much the commentary, which I agree with there, is that it needs a whole end-to-end approach. I think we can't just focus on this at the back end. I think we have to also focus on this right at the front end, health and social care,

vulnerable populations and offending and sentencing, and so on.

That being said, the short answer is, yes, I think that if the investment is made wisely, the investment will bear dividends, but it has to be done in partnership with corrections and justice, and the police, to make that work.

PO Thank you.

Mr RICE, just two things. One is the brochure that has been referred to that talks about the offender health review and the five themes. Did you want to tender that brochure?

That's public, I think you said, doctor, is it?

W Sorry, the consumer perspective one, I think, has already been tendered.

PO Yes, that has gone in. The other brochure that talks about the five themes -- I thought you said that was public-

CA It is only the information sheet that we have tendered.

PO That's all right. We don't need to do the other.

The other thing is the report that Dr WAKEFIELD just mentioned that came down, referred to in the Four Corners report, the House of Commons' most recent report. We probably should tender that if you have a copy.

CA Yes, I have been provided with a copy of that, conveniently published on 1 November this year. It's entitled Prison Health, a report of the Health and Social Care Committee to the House of Commons. I tender that, Commissioner.

PO I'll make that exhibit 107.

ADMITTED AND MARKED EXHIBIT 107

PO Thank you.

Mr MURDOCH, do you have any questions?

LR No, may it please the Commissioner.

PO Thank you very much.

Thanks very much, Dr WAKEFIELD, for coming in. Thanks for the amount of work you have done to present your evidence today. It's much appreciated by the inquiry.

Mr RICE, you have two other witnesses at 6 o'clock from Vienna by Skype, I understand?

CA Yes, overseas witnesses. We will take their evidence electronically.

PO That's at 6 o'clock?

CA Yes.

PO All right. We will adjourn now until 6 o'clock. You are excused.

END OF SESSION

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