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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 7 – TUESDAY 22 MAY 2018
(DURATION: 2 HRS 37 MINS)

LEGEND

PO Presiding Officer – ALAN MACSPORRAN QC
CA Counsel Assisting – GLEN RICE QC
INST Instructing – AMANDA BRIDGEMAN
HRO Hearing Room Orderly – ISABELLA PATTON
W Witness – SAMAY VADIR ZHOUAND
CM CHRISTOPHER MURDOCH, Crown Law (QCS)
DP D PEVERILL (United Voice)

PO Good morning. Mr RICE?

CA Thank you, Mr Commissioner. It is proposed this morning to recall Mr ZHOUAND.

Before that, could I perhaps indicate that Mr PEVERILL from the United Voice Union is in attendance. Commissioner, you might recall he attended the other day, in company with Mr DAVIE, as representatives of that union. He has an application to conduct some, he advises, limited cross-examination of Mr ZHOUAND. Perhaps he could make that application and inform you of the scope of it?

PO Yes, certainly.

Mr PEVERILL, just come forward, if you wouldn't mind.

DP Good morning, Commissioner. I appear today for United Voice. We are a stakeholder and have provided a submission in this matter. We seek leave this morning to make some limited cross-examination of Mr ZHOUAND. We understand that he is being cross-examined by counsel assisting. There is some information on transcript which we wish to put to Mr ZHOUAND in a limited fashion.

I do intend to take him to the snapshot report of 2017. There is some data in there which United Voice says is relevant to not just our submission but the terms of reference that the Commission has been convened on. I don't expect that will take any longer than five or so minutes, Commissioner.

PO I am happy to give you leave, Mr PEVERILL. That's fine.

DP Thank you.

PO Yes, Mr RICE?

CA Commissioner, I recall Samay ZHOUAND.

PO Mr ZHOUAND, you remain under your former oath. Thank you. Mr RICE.

CA Thank you.

Mr ZHOUAND, do you recall when we finished your last session of evidence, we had been discussing some of the healthy prison reports. I would like to move on from that to some instances of incident reports.

W Sure. Mr RICE, could I just clarify, I did check that issue about Brisbane Women's, regarding your questioning about that and the safety order numbers in Brisbane Women's.

CA Do you want to say something about that?

W Yes, I can just clarify that the behaviour management unit was not operating at the time when we did that inspection, so those segregated prisoners were largely in the DU and SU, the safety unit, at the time.

CA That was at Brisbane Women's?

W That's right, but I just want to add that I think on page 18 of the report, we still raised the issue of segregation as a significant issue in the report.

CA I want to take you to some incident reports. I don't want to disadvantage you. I will show you this.

W Sure.

CA Take what time you need to orientate yourself with respect to each one.

W Yes.

CA Could I show you this report that's dated 25 September 2017. Is that a report by way of memo that you gave to the then Acting Commissioner of Corrective Services?

W That's correct.

CA It concerns an incident involving a prisoner at Wolston Correctional Centre?

W That's correct.

CA Can I ask you, firstly, just about the format of this. One observes that it is different in format from the perhaps more formal incident reports. Why would that be?

W Resources. Ultimately, in a perfect world, we would do a much more detailed report, which fully lays out all the evidence, all the research, and so on, but we're a busy unit, and where resources are thin but we still find significant issues, we highlight those through, I suppose, less-detailed reports by way of memos and so on.

CA Does the format of the report relate to the scope of the investigation - the size of the incident and the scope of the investigation that results?

W Not necessarily. We have highlighted some significant issues through by way of memos as well, and I think it's just really a question of capacity. Usually with our investigations and incident investigations, they require a lot more resources, they require a lot more time. But some issues we review, the issues appear, on the face of them, to be very clear, and then, whether they're significant or not, we make observations, findings and recommendations in relation to those.

CA Commissioner, I will tender that memorandum of 25 September 2017.

PO Exhibit 53.

ADMITTED AND MARKED EXHIBIT 53

CA This involved an incident, did it not, with a prisoner at the centre being seriously noncompliant and seriously self-harming over a long period?

W I think so. As I recall, that's the case, yes.

CA A period of about 20 hours, in fact?

W Yes. As I recall, that's the case, yes.

CA He was required to be taken to the Princess Alexandra Hospital on two occasions during that period of self-harm?

W That's correct as I recall, yes.

CA He had effected some self-harm, I think, and was bleeding quite seriously, at least at one point?

W That's correct.

CA How would an incident like that come to your attention?

W There are two ways - well, there are multiple ways.

Firstly, to the extent that we can with the resources we have, we review incident reports that occurred during the previous day. On IOMS, there is a list of incidents. There's too many to count, but we conduct a perusal, focusing on ones that might relate to potentially, for example, something serious, and so on, and we also get information from what we call, I suppose, incident alerts. Essentially, when an incident is reported, an alert goes up to a number of key individuals across the agency, ranging from senior management to middle management to specific officers. We review some of those as well.

Incident awareness can also come to us through our intelligence sources and information. Staff might call us and say, "You might wish to have a look at this", and so on. We get that information, and then where we say, "Well, hold on, this doesn't sound right. Given the nature and level of the incident, on the face of it, and the response seems to be a bit excessive, let's have more of a look in relation to it", in those circumstances, we ask for CCTV or we look at IOMS, look at any attached information, and so on, and then make an analysis in relation to that.

CA Just in relation to the incident reports and your office's review of them, is it right that incidents within centres are classified according to a scale?

W Yes.

CA Is it a 1 to 3 scale?

W Yes.

CA Could you just give us an idea of what each scale consists of? Is level 1 the most serious?

W Level 1 is the most serious. It would, for example, include serious assaults, where there's injury, overnight medical treatment, major disturbances, and so on.

Level 2 is, I think, more general assaults where they do result in injury

but perhaps not overnight medical treatment.

Level 3 are less serious items. Nothing immediately comes to mind, but generally they're classified to be less serious.

CA Does the author of the incident report give it that classification?

W How it should work is, as I understand - and then the Deputy Commissioner, Statewide Operations can assist more, and so can the general manager of strategy and governance, but essentially what should happen is that there's an incident; all relevant officers involved in the incident complete officer reports, and then the supervisor classifies the report, it goes through the relevant manager in the centre, and then it's signed off at a manager or deputy manager or general manager level, depending on the matter. It gets reported and then there's an assurance framework within Statewide Operations, and then there's also a reporting services office unit within strategy and governance that looks at reporting incident codes as part of incident reporting and data reporting for government and for the agency. Then we have a role in terms of it, to the extent with our resources permitting, as part of our oversight functions, where we try to look at incidents to the extent that we can, and if we identify issues, we raise them with QCS.

CA Did I understand you that your office is involved in reviewing incident reports from each centre?

W Yes, but I just want to clarify that we don't review every incident.

CA I was going to ask you, because there are a great many, aren't there?

W Because it's just not possible. There are days where we don't review incidents at all, because all the inspectors are out. We don't have that many resources. We're doing inspections, investigations, but we do think that it's an important function, and even though it is not legislated, we have incorporated it as part of our general functions.

CA This particular memorandum is under your hand. Do you recall whether you did the investigation into this?

W No. As I recall, it was an inspector at the time in my office. I think at the time - I can't recall whether it was me or him that raised some initial thoughts about this matter, and then we determined that it was appropriate to look into it further. Then, essentially, either I asked him to do it or I agreed for him to look into it a bit further.

CA One of the features of what happened in this incident, as we see, I think, from heading 2 on page 2, is that upon being returned to the centre from the hospital, he was carried by four officers, each carrying one limb, with the prisoner face-up?

W Yes.

CA I think, as we see from heading 5, he was returned to a cell which still had a fair amount of blood within it?

W Correct.

CA Are those the features that attracted attention?

W Look, I'd be speculating. I can't recall.

CA That what's described as an "escort of prisoner", would that qualify as a use of force?

W In terms of them doing that, technically it would, but we don't necessarily - in terms of the use of restraints. But in terms of them carrying him, look, I can't recall the specific video at the time, but I think from what I recall in this instance, the issue we had with them carrying him was more about the human dignity aspect of it, as I recall, in terms of perhaps it was a bit demeaning in-

CA Well, an assessment was made, and you have submitted it, as we see on page 3, that the approach that was taken by the officers in that admittedly difficult situation was described as being more punitive than therapeutic or recovery focused. Presumably that was the view that the investigator took, and you have accepted that and submitted it accordingly; correct?

W That's correct.

CA Mention is made under the "Summary" heading that perhaps there might be some professional development in terms of managing what is described as compassion fatigue, and that is reflected also at heading 8 in terms of a recommendation that there be some professional development to deal with that.

Using that as an example, if it were accepted by the Commissioner that professional development would be a good idea for those staff, how would that be acted on in terms of process?

W Essentially what happens in terms of process, where I do send information like this to the Commissioner, the Commissioner would refer it to the appropriate board of management member, and usually it's either Deputy Commissioner, Statewide Operations as the matters relate to that function, or to the Executive Director, Specialist Operations, or to the Executive Director, Operational Support Services, which might be responsible for the private prisons.

In this instance, I would imagine if the Commissioner - as I read this, I can see the commentary written by the Commissioner. But normally if the Commissioner determined it appropriate to progress it, it would be referred, for example, to the Deputy Commissioner, Statewide Operations for consideration and implementation.

CA Tell us, if you can, would the Deputy Commissioner in that instance - if he or she accepted that this kind of professional attention was worthwhile and warranted, would that go back to the centre? How would it filter back to the particular officers?

W I think that's something you would need to refer to the Deputy Commissioner, Statewide Operations.

CA Okay. This is a particular incident of a particular type.

W Yes.

CA Can I suggest that it does raise the question of what's called "compassion fatigue". In relation to a report such as this, is the report given any wider significance for what it might reveal than the particular incident focused on a particular centre? Do you know what I mean? An incident like this, where staff are under a position of difficulty, stress, probably - is there any mechanism for that to be elevated to a wider issue of concern that might be addressed across centres?

W I think that's something that is largely up to the relevant board of management member in terms of if we do make findings and recommendations. Essentially it is a process where I submit my reports to the Commissioner with these types of matters, and it's as deemed appropriate by the Commissioner to the relevant board of management member that it goes to, and then it's up to that board of management member as to who in his or her directorate he or she may wish to share the information with and how they might respond.

CA This, as an instance, goes to the Commissioner?

W Yes.

CA You say, from there, it may be referred to the relevant board of management member?

W Yes.

CA In this instance, it would be the Deputy Commissioner, Statewide Operations?

W That's right.

CA And then he would determine what's to happen to it; correct?

W That's right.

CA Including whether something might be revealed from the incident that might have wider interest or circulation beyond the particular centre, do you know?

W Yes. For example, if this went to the Deputy Commissioner, I would presume - I suppose I don't want to speculate, but the Deputy Commissioner would, for example, have a process around what reports he or she distributes to centres, and so on. I would leave it up to him to answer in respect of those specific processes.

CA You don't know, I take it, whether there is any process or pattern of using your incident reports for the learning that they might reveal and distributing it more widely amongst centres?

W I am aware that Statewide Operations has a statewide, I suppose, governance and assurance sub-unit, and I do know that the reports go to that unit. I'm unfamiliar as to the particulars of how they further communicate and deal with that.

CA The Deputy Commissioner would know that; correct?

W Yes, yes.

CA Do you happen to know whether some form of professional development to deal with issues of fatigue, mental fatigue, by officers is available?

W As far as I'm aware, no. As far as I'm aware, no.

CA That was the recommendation, wasn't it?

W Yes.

CA If it is to be acted on, I take it that it would have to be acted on by some means other than the regular training regime?

W Yes. I suppose I should clarify that. I am aware that, in the past, QCS has done, I suppose, workshops, and so on, in regards to resilience. But as to the extent or full nature of it, I don't know; or the specifics of this matter, I'm not aware of anything.

CA Again, this was a particular incident of a particular type.

W Yes.

CA Would you accept that incidents raising the prospect of a degree of mental fatigue on the part of officers would not be particularly unusual?

W As I recall, this was the first time we used the terminology. Having said that, we have raised reports, as I know board members have raised reports, that staff are really tired, and I think overcapacity is a big issue.

CA Correct.

W Staff are impacted, and they're doing their best and they are really tired. I think that's generally understood.

CA It is a question of what, then, is done about that.

W That's right.

CA And this is an instance.

W Absolutely.

CA Do you know the answer to that?

W I'll have to refer you to the Deputy Commissioner, Statewide Operations.

CA That's okay. Another issue that was raised in this case was the absence of body-worn cameras. We see that at heading number 1. Again, perhaps it raises question not just of a particular incident but perhaps of-

W Broader.

CA -policy concerning the use of body-worn cameras. Hence my interest in the extent to which this incident might reveal something of more useful wider application.

W Yes.

CA In the end, it would be a matter, from what you tell us, of how the Deputy Commissioner, in this instance, chooses to treat the matter?

W Yes, the Deputy Commissioner and the Commissioner. I suppose the Commissioner determines which board of management member it goes to, and then that board of management member consults, as I understand, with their relevant staff about it, and then they deem, as appropriate from their perspective, as to whether they should carry it out or not or distribute it more broadly, and so on. In broad terms, that's how I understand it.

CA Would it be open to the Commissioner to view that and say, hypothetically, for example, there is an issue with body-worn cameras and give direction to the Deputy Commissioner to look into that further?

W I will leave that up to the Commissioner to determine, but generally it's really up to the relevant BOM member whose portfolio matter it is to determine the issue. The Commissioner is guided by some advice in terms of the operational impacts of recommendations and issues, and so on. Ultimately it will be up to the relevant BOM member and their advice.

CA You speak of the relevant board member. In the case of these incidents classified as 1 to 3, is there any other relevant board member apart from the Deputy Commissioner, Statewide Operations?

W As I said before, sometimes it will be the Executive Director, Specialist Operations. For example, there might be a brief or a memo in relation to the management of someone in - I can't recall anything specific, but it might be in relation to the management of someone in the maximum-security unit in terms of their classification and placement, so something like that.

Traditionally, for example, where that executive director's delegation was responsible for safety orders, if there were issues with safety orders, it would have been, in part, referred, as I understand, to that executive director as well.

CA Let's go to the next example. This one involves a memorandum from you to the Acting Commissioner on 7 September 2017. Can I show you that memo. Is that a memorandum from you to the Acting Commissioner at the time?

W That's correct.

CA Dealing with an incident at Brisbane Correctional Centre?

W That's correct.

CA I tender that memorandum of 7 September 2017.

PO Exhibit 54.

ADMITTED AND MARKED EXHIBIT 54

CA Would this also have been investigated by an inspector other than you?

W Yes.

CA Have you had a chance, before coming here, to look at this memorandum?

W Yes. It was last week, and a lot has happened in the last week.

CA I understand that.

W But I'm happy to answer any questions you may have.

CA Just to give it some focus, there was an incident of assault occurring, or perhaps attempted assault, by a prisoner on a correctional services officer at the centre?

W That's correct.

CA The assault involved a particular correctional officer, but then a number of other officers attended to render assistance.

W That's correct.

CA There was a question of whether excessive force had been used.

W That's correct.

CA The inspector was involved in reviewing the available evidence, principally that available by virtue of film?

W That's correct.

CA Correct me if I'm wrong: the scenario was that CCTV footage was viewed, but, in the scheme of things, that didn't contain any sound; correct?

W That's correct.

CA As it happened, a number of body-worn cameras were being worn, and I think there is reference to four in particular as having been deployed in the course of that incident?

W As I recall, that is correct, yes.

CA One of the features that is referred to in the last paragraph on the first page is that in relation to what's called the primary camera - that is, the one that the officer allegedly assaulted was wearing - there was no sound for the first 30 seconds or so, when there was a verbal exchange, which might have revealed the cause or trigger for the assault that followed. Is there any defect in the equipment that would result in a gap of sound being recorded for 30 seconds?

W I can't recall as to whether it was a defect of equipment or whether it's just

the functionality of the equipment that is limited, but I think what we noted in this document was that it would greatly assist in terms of determining the cause or the drivers for an incident if there was sound, as you can't get all the information from visual alone.

Having said that, I would just like to add that my opinion is that, on the whole, the fact that we have body cameras is a great thing. It would be enhanced if there was full functionality of sound as well.

CA Do you know whether the camera can be recording film but not sound for the first 30 seconds?

W Yes, as I understand - look, as to the technicality of it, I'll have to refer to relevant experts, but what I understand is that the camera is technically recording all the time, but it deletes itself, and then if something happens, the officers press a button and then the camera automatically saves the previous 30 seconds.

In this instance, I can't recall, but we made a determination that there was no sound and that, in this instance, it was significant in terms of actually not assisting in terms of determining what was the driver of the incident, which might have been a little bit vague as to whether the response was appropriate or not in the circumstances.

CA Who would be best placed to speak about this kind of technical issue?

W In terms of the camera technology aspect, I would refer you to the Executive Director, Operational Support Services, John FORSTER, in terms of some of those technical capability issues, yes.

CA Another feature, as we see from the top of page 2, is that the primary camera became dislodged and, upon being dislodged, focused on a wall rather than on the incident.

W That's correct.

CA You may or may not know - tell us if you do - how easily a body-worn camera can be dislodged?

W I don't know, so I would be speculating.

CA As we see from the second dot point on page 2, the additional feature of it is that perhaps even before being dislodged, the camera angle was such that it didn't really capture much of what was going on.

W That's correct.

CA Do you know if there is any difficulty in achieving an appropriate orientation of the camera?

W As to the technicalities, I would have to refer you to the Deputy Commissioner, Statewide Operations. I suppose, from my perspective, from an oversight perspective, what would be good is that the cameras, in an ideal sense, not only record sound but also are not easily dislodged, because if they are easily dislodged, what we will have are very important critical incidents against staff for their safety or that happen in respect of

prisoners that are not properly captured. Hence it makes the issue of making appropriate findings and recommendations and taking appropriate responsive action from an accountability perspective very limited.

CA In addition to the difficulties with the primary camera, when other officers attended, it seems from the paragraph on page 2 above the heading "Findings" that none of those was orientated in such a way as to capture much of assistance that would have assisted to assess the incident; correct?

W That's what we found, yes.

CA The inspector, you have apparently agreed, was of the view that it appeared that the cameras were avoiding focusing on the prisoner. Do you see that in the middle of that paragraph?

W Yes. I think that was the conclusion drawn. Since that time, I have reviewed the footage, and my view is, yes, you could interpret that, but it is a little bit more grey as well. Having said that, yes, I confirm that that's the conclusion we made at that time.

CA It's something that a reasonable person could infer, could they not, if there were several cameras deployed, but none of them actually recorded anything of note?

W That's right. Minds may differ, but, yes, a reasonable person could interpret that.

CA This kind of a conclusion relevant to the use of body cameras, would that be a subject of wider concern than perhaps the incident in itself?

W Yes, it potentially could be. Again, the process there is that it is referred to the Commissioner, and the Commissioner refers it to the relevant - as he or she deems appropriate; at the time, I know the Commissioner was a she - as they determine appropriate, and then it's up to, I suppose, the relevant BOM member to determine what appropriate, if any, action needs to be done and whether it is local, extensive and so on.

CA This, again, would fall in the province of Statewide Operations?

W In that instance, I think so, yes.

PO Mr ZHOUAND, can I just ask you, is there no mandated positioning of the camera on the uniform?

W As I understand, Mr MACSPORRAN, I think - I'd be speculating, but from what I understand generally it is just in the chest area. That's all I understand.

CA You would expect there to be some training on its use, wouldn't you, so that it achieves its purpose?

W Yes, I would imagine that there would need to be some training, yes.

CA Can I move to the next example, Mr ZHOUAND, which involves a report from your office concerning an incident at Arthur Gorrie in August 2016.

Can I show you an abbreviated version of that report.

W Thank you.

CA Just take your time and have a look at it.

W Yes, I recall.

CA Is that an abbreviated version of a report from your office dealing with that incident at Arthur Gorrie in August 2016?

W Yes, that seems to be the case.

CA I tender that copy.

PO Exhibit 55.

ADMITTED AND MARKED EXHIBIT 55

CA The facts are summarised on page 6. Just to recap on it, there was an incident in a unit at Arthur Gorrie, lasting, it looks like, about 30 minutes or so, in which a number of prisoners took exception, I think, to the treatment of one prisoner and it was classified, I think, as a mini riot.

W Yes.

CA After about 30 minutes, a CERT team and a dog handler were used to assist to bring the situation back to good order; correct? The circumstances were that prior to the insertion of the CERT team, those prisoners who had been in a yard, previously perhaps noncompliant, were rendered compliant?

W Yes.

CA By the time of the entry of the officers into the yard, which the prisoners had had about 30 minutes of control over, they were lying face down?

W That's correct.

CA In a compliant fashion?

W That's right.

CA Upon entry of the officers into that scene?

W That's correct.

CA And then some use of force followed?

W That's correct.

CA On persons who had been difficult but were, by then, lying down in a compliant fashion?

W It appeared, yes, to us, on the face of it, that that was the case, absolutely.

CA There was application of some capsicum spray in that scenario?

W That's correct.

CA And also some baton strikes?

W I can't specifically recall that, but I have no reason to doubt what you are saying.

CA There were some findings about that. We don't need to go into all the details-

W Yes, no, absolutely. Yes.

CA -but just go to what the inspectors found.

W Yes, absolutely.

CA Do you have page 47 there? In that scenario, finding 3 was that capsicum spray was deployed unlawfully?

W Yes, that's correct.

CA "Unlawfully" would be a reference, would it not, to section 143 of the *Corrective Services Act*?

W That's correct.

CA That sets out the parameters of the use of force?

W That's correct.

CA And there was a breach of that in this instance?

W Yes, that was our view.

CA In addition to the capsicum spray, there was additional application of force on other prisoners, as appears from finding 4?

W Yes.

CA In a punitive fashion, in retribution for the disruption that had apparently occurred; correct?

W Yes, that's correct.

CA As to that, the inspectors made a conclusion, in finding 6, that some elements - and in context, that must be some elements of the correctional service officers-

W Yes.

CA -had a poor understanding of section 143 and also policy and procedures surrounding use of force. They go on to say that this incident wasn't an isolated incident of officers not complying with section 143, et cetera.

By the way, would an incident of this type classify as one of the major incidents at level 1?

W Yes, it would.

CA There is a particular reporting mechanism that attaches to that, isn't there? By that, I mean rather than just an incident report being filed in the usual way, isn't there some contemporaneous notification that has to be given?

W Absolutely, yes. As I understand, with significant incidents and so on, what usually happens, be it the general manager of a public prison or the relevant private prison, they do inform Statewide Operations about the occurrence of the incident, and then there's some, I suppose, involvement from an operational perspective from Statewide Operations.

CA The notification is given at the time?

W Yes, that's correct.

CA Or as near to it as possible?

W Yes, that's correct.

CA So that senior officers can be aware that there is a level 1 incident?

W That's right.

CA Is that the idea?

W That's right.

CA One of the other features of this, we see from page 49 at paragraph (c), was that there was what appeared to be the inspectors to be some kind of warning that body cameras were being used and were capturing film?

W Yes. I think at the time - can you ask your question again, sorry?

CA You see paragraph (c)?

W Yes.

CA The inspectors queried the necessity for what appeared to be a warning that the camera was on.

W Yes. I do recall that.

CA Noting that if the officers were acting appropriately, there's no need to give a warning?

W That's right.

CA Level 1 incidents are relatively uncommon; would that be correct?

W I would say they're less common, obviously, than the other type of incidents, but they do occur on a regular basis. There are degrees of level 1 incidents, I suppose is the best way to put it, and this one is one of

those on the high scale.

CA We see from page 48, paragraph 1(a), that the officers informed inspectors, in relation to the use of the cameras, that they had received limited training and had related to technical things like how to sign it out and how to switch it on and off, and so forth.

W Yes.

CA The appropriate use of body cameras is, can I suggest, a topic of general interest across QCS?

W I would imagine it would be a relevant - yes, absolutely.

CA Particularly the appropriate use of it during a level 1 incident would be a matter of general interest within QCS? I was going to raise the same thing, and you will probably give me the same answer: is there some learning or experience that comes out of an incident like this that could be applied to educate those concerned in centres other than Arthur Gorrie?

W I think learnings can be gained from every incident, absolutely, and, if they're relevant, have broader statewide applications, absolutely.

CA This was a very detailed investigation, as we can see from the length of the report.

W Yes. Can I just clarify, Mr RICE, as I understand, Arthur Gorrie has a different body camera system than the public centres.

CA Do they not use the same equipment?

W No. As I understand, it's a different one, so that might be an area of distinction.

CA Understood.

W But from a broader learning perspective, absolutely there can potentially be learnings as well.

CA It turns out, as we see from para 2 on page 48, that at that particular centre there was a use of force review committee but that it didn't apply itself to this incident, apparently erroneously thinking that because it was being investigated by others, including you, such a review wasn't necessary?

W Yes. I suppose our conclusion there was derived from the fact that the first and second layers of governance still need to do their job. They can't absolve themselves of responsibility, and they need to do their work as well. I think that's where that came from.

CA So are you saying that independently of your investigation of this matter, or your office's investigation, there is some obligation on the centre to conduct its own review of such an incident?

W Essentially, after each significant incident, there needs to be an incident debrief where there have to be learnings from it. And also both - I'll speak about private centres in one second. From a statewide perspective,

obviously they have their assurance framework in terms of, as part of that, they've got an incident management review committee, where they do review such incidents as well. And private centres, as well, should be reviewing incidents, like they do here, significant incidents - obviously it's problematic to review every single incident, but significant incidents, to gain learnings from them themselves as well.

CA Would this report then go to the Commissioner?

W Yes.

CA From there, would you expect, in the ordinary course, that it would be referred to the appropriate board member?

W What happens in this instance is that it goes to the Commissioner, and before it actually goes to the Commissioner, it gets distributed to all board of management members through a consultation process.

CA Why would the distribution of this report be different from the previous ones, which didn't have that wider circulation?

W This is a more formalised incident reporting process, which is much more detailed and covers a greater deal of matters and issues. Under that process, what happens is that it gets sent to relevant BOM members to let us know if they have any concerns about errors of fact or finding or recommendations. They give their response. We assess it. To the extent we agree, we agree. To the extent we don't, we don't.

Then the report is finalised. It goes to the Commissioner. Upon the Commissioner's signing or taking of the agreement, it gets distributed to all BOM members, and the relevant BOM members who are responsible for carrying out the relevant remediations have to carry them out.

For incidents, the responses go to the incident oversight committee. In terms of the incident oversight committee, what happens is that the relevant directorates provide the implementation responses to the recommendations to the incident oversight committee, which meets on a quarterly basis.

CA Under whose span of control does the incident oversight committee fall?

W The incident oversight committee reviews incident investigation recommendations, like incidents investigated by the Office of the Chief Inspector under the *Corrective Services Act*. I'm the chair of that committee. That committee is comprised of a number of other board of management members, and, as I said before, it meets on a quarterly basis.

CA A report of this kind, we could expect, would be considered by the incident oversight committee?

W The report would be referred to board of management members, and then the committee largely focuses on the implementation in response to the specific recommendations.

CA Such implementation as may have been recommended - are the recommendations that might be made modified by any board member by

the time they come back to the incident oversight committee for implementation?

W In that situation, what happens is that the relevant board of management member - and in this case, Arthur Gorrie, I suppose the Executive Director, Operational Support Services, through the contract management unit, is the facilitator of information provided by the private providers, but essentially they complete a form and sign off on a form advising what their position is in terms of whether they have appropriately responded to the relevant incident investigations. They provide documentary evidence in terms of doing it.

It comes to my office. We provide secretariat and essentially we do the secretariat functions. Then it goes before the committee, and then, as a committee, the committee decides whether enough information has been provided to sign off on the recommendation. To the extent that any members have concerns in respect of that, they note it in the minutes if the majority agree that it should be endorsed.

CA You mentioned, if I understand correctly, that for a report like this, individual board members would be apprised of the report?

W Yes.

CA But would the report be considered at board level as part of deliberations in the course of a meeting?

W No, not - no.

CA So is the report referred to the board members simply for feedback on accuracy?

W There are two purposes. One is from a consultation process, yes, but it's also to alert them at an early time what might be the issues with it, when the final report is submitted, so it's responding to the findings and recommendations, and those findings and recommendations that they consider and respond appropriately, so that can be implementing specifically specific recommendations or it could be other things from it as they deem appropriate for their directorate.

CA I think you did say before, but could you tell me again who would be the designated board member for this kind of report involving Arthur Gorrie?

W In this instance, in terms of the responses to the recommendations, I can't recall. I can't recall the specific recommendations, but I think, from memory, they largely related to recommendations directly to the centre itself.

In that situation, the office that would be responding to the incident oversight committee in regard to the specific recommendations, as it relates to the reporting requirement under the ISE - that would have been the Executive Director, Operational Support Services, John FORSTER.

CA Just for completeness, one of the other features of the conclusions about this, as appears from page 51, is that the inspectors were satisfied that the officer reports from staff were "inadequate and lacked necessary detail"

and, as appears in paragraph (c), that was the product of lack of training and awareness, et cetera. I am probably labouring the point, but the experience of an incident like this might have wider implication for officers' training?

W Absolutely.

CA Particularly at Arthur Gorrie?

W Absolutely.

CA I am just curious, then, to understand if there is any mechanism for the learning coming out of this to be applied across QCS.

W The mechanism for the learning is ultimately relevant BOM members reading the report and determining what might be the learnings for them or their directorates in respect of it. Where there are systematic issues, I suppose, we highlight those in the reports through a root cause process. I think at the time for this one, we mightn't have had a root cause process operating at the time. But where there are systematic learnings, we do that through a root cause process, and, again, BOM members would be reading that and determining the learnings from that and sharing it with relevant bodies as appropriate.

CA Is there any individual or board member whose responsibility it would be to view such a report and distill from it experience and learning which is relevant to the application of all centres and to refer it to those centres for that reason?

W I suppose, when you put the question that way, the appropriate entity or office would be the Deputy Commissioner, Statewide Operations.

CA Can I just take the next example, which involves a report from your office of an incident at Maryborough in October 2014. Is that an abbreviated report of that incident?

W That's correct.

CA I tender that report of the incident at Maryborough on 12 October 2014.

PO Exhibit 56.

ADMITTED AND MARKED EXHIBIT 56

CA The incident, in summary, involved four prisoners scaling a fence, climbing onto a roof of a unit and staying there for quite a long time; correct?

W That's correct.

CA In fact, as we see from paragraph 2.11, I think, on page 4, the duration of the incident occurred over three shifts and, accordingly, involved about 35 officers before the prisoners concerned were able to be removed and brought back into the mainstream, so to speak?

W That's correct.

CA Like the previous incident at Arthur Gorrie, this, by its nature, was classified as a level 1 incident?

W That's correct.

CA As for the findings and features of it, would you have a look at pages 24 and 25. The principal finding coming out of it was that there had been inadequate reporting by quite a number of officers; correct?

W Yes.

CA As we see from paragraph 3.123, in discussion with the general manager, it was apparent that some new system or new approach to reporting was being devised because of previous poor compliance.

W That's correct.

CA So the same issue was raised of poor reporting as was raised in the Arthur Gorrie incident, although this one actually occurred first?

W Yes, and I think from memory, with this one - I'm a bit sketchy in terms of the particular circumstances with the Arthur Gorrie one, but I do recall with this one that there was an arrangement which essentially meant that multiple officers were involved in the incident, and then the question was which one of these officers has to complete a report? Do we get 35 reports, with some officers being tangentially involved, and so on?

Ultimately I think what happened was - I think it was the general manager in this instance, or someone relatively senior, who basically said, "Okay, what did you see? What did you see? What did you see?", and then determined, "Okay, you provide a report. You provide a report." Essentially I think about six or seven people were asked to provide a report, from memory, and we raised some questions about that from a filtering perspective, and-

CA What do you mean by that, sorry?

W I suppose the question we raised was that when an incident occurs, you want to get as much information about the incident as possible. If there is a determination made down the reporting line as to who should provide a report and who shouldn't, then essentially what happens is that oversight entities, such as ourselves and potentially ESU or CCC, and so on, might not get all the information. So that's what we meant, not necessarily accusing anyone of anything, but we thought that that was the risk with it and we raised that in that report.

CA In this incident, was this the conclusion, that that rather large number of officers who were involved across the three shifts should really each have contributed a report as to their participation in it?

W I think that was - yes. I can't remember specifically, so I will have to read it and consider it, but I think that that was the line. We were saying, yes, there is an issue with having such a low number and there's an issue with somebody filtering it along the way, and more officers should be able to provide reports.

CA This level 1 incident, by contrast with the previous one we looked at, involves a public centre, being Maryborough. How would that affect the treatment of this report? Do you know what I mean by "treatment"? The process you described earlier of it being given to the Commissioner and then being-

W No, no different whatsoever, insofar as upon it going to the Commissioner, it gets distributed to all relevant BOM members, including the Deputy Commissioner, and then they take their remediations in response to the report or any other action they deem appropriate. Then in terms of the remediations in regard to the specific recommendations, they provide a response to the incident oversight committee, which reviews it, and then that's it.

CA I think we have heard this before, but I have just forgotten the answer to it. You may be able to tell me. Are the general managers members of the board of management?

W No, they're not. The Deputy Commissioner, Statewide Operations is, but not the general managers.

CA Is there any mechanism by which a general manager, say in Townsville, could learn of this report?

W I will have to refer you to the Deputy Commissioner, Statewide Operations for that.

CA Would it be his call to determine whether this report might be of interest from an educational and security point of view to general managers?

W I think it would be - yes, if any BOM member determines there are learnings from a report that should be shared with their managers and directors, it's up to that BOM member to share that. From time to time, some of these reports do contain sensitive personal information and individual circumstances, and some discretion has to be exercised in respect of that. But other than that, it's up to the relevant BOM member as to how they respond to the report.

CA Is identification a problem? The Commission has taken the trouble to ensure that this is de-identified.

W Yes.

CA Is the identification and naming of prisoners and officers any kind of barrier to wider circulation of this for such assistance as it might give to general managers?

W On the face of it, no, I don't see - yes.

CA Can I go to the last of this sequence of incidents.

W Sure.

CA This concerns a report into the management of a prisoner at Wolston in August 2015. Is that an abbreviated copy of that report?

W That's correct.

CA I tender that copy report in relation to the incident at Wolston in February 2015.

PO Exhibit 57.

ADMITTED AND MARKED EXHIBIT 57

CA As a matter of process, in the introduction, which appears on page 3, this particular incident, by the time your office had prepared a report, had apparently been investigated by ESU?

W I can't recall the specific circumstances, but I think it did, because we did refer to the ESU investigation in this document, yes.

CA That's what I mean. Do you see at para 1.3 there is reference to findings from the ESU investigation-

W Yes, I see. You're right, yes.

CA -which by then obviously were available for you to include in the report?

W Yes.

CA So that it presumably must have preceded at least the preparation of your report?

W Yes.

CA In the end, both ESU and your office investigated the same incident?

W Yes.

CA With a different object, I suppose?

W Yes, with a different object, yes.

CA ESU investigated to determine whether there was misconduct and what sanction might apply; correct?

W That's right.

CA Perhaps you might tell us, then, what would be the focus of interest from your office?

W I suppose the way we explain it when we talk to interviewees and generally in terms of how we do it is that - and I will bring CSIU into it as well. CSIU look at it to determine whether criminal offences have occurred. Ethical Standards looks at it-

CA I'm sorry, which comes first or does it all come together? We have potentially three areas of interest: CSIU, ESU and your office.

W Yes.

CA Do you all get the same information?

W Not necessarily in terms of it, but generally in terms of that process, I suppose if there is an allegation of corrupt conduct or something of that nature, the practice is that, for example, through the OVs or through an inspection process, we collate that information to the extent that we have. We don't investigate that matter. We refer it directly to ESU and CSIU as appropriate.

But in certain circumstances, such as this - I don't recall the issue of CSIU in this particular circumstance, but our general approach - I suppose I was answering your question about, well, what is their focus and what is our focus? What I was saying there was that CSIU's focus is criminal conduct and ESU's focus is corrupt and misconduct, and our focus is to ensure that from professional policies, procedures and quality assurance, the system was doing the right thing and to see if this type of incident can be prevented in the future.

CA This involved an application of force on an admittedly difficult prisoner; correct?

W Yes.

CA But it seems as though the officers concerned - and I am looking at paragraphs 1.4 and 1.3, the thirst-last dot point - didn't make any report of the incident and that it only came to light when the prisoner telephoned the Crime and Corruption Commission to make a report about it.

W Yes.

CA Would that qualify as a major incident of non-reporting or under-reporting?

W That would qualify as a major incident of non-reporting.

CA As to that, if we go to the conclusion expressed at paragraph 2.17, there was non-reporting not only by the officers directly involved but also by officer witnesses; correct?

W That's correct.

CA So no-one did a report about it; correct?

W Yes, that's correct.

CA There were probably seven who should have done?

W That's correct.

CA The reference in paragraph 2.17 is that perhaps the five witnesses may have had an incorrect belief that it was not necessary to report because their supervisor had the situation in hand, and there was a practice of completing an officer report only if asked to do so by a supervisor?

W That's right.

CA Is that a good practice?

W No. We found an issue with that as part of the investigation, and I think we made a systematic finding that that was a system issue in some respects.

In that particular incident, as I recall, I think the practice at Wolston in respect of that incident - and we interviewed many, many people. It seemed to be generally the case that people automatically referred to the supervisor as to whether an incident should be written or not, even though the procedure might necessarily say something else. In this instance, it was clearly a reportable incident, and, as I understand, as I recall, I think a determination was made not to report it, and hence the officers involved in it just accepted that.

We, as part of our systematic finding, determined that that is due to one of key reasons. I think one is following the line of authority. That seems to be part of the system.

CA That's the reference to the chain of command mentality that appears in the report?

W That's right, that's right.

CA Officers witnessing an incident such as occurred, as a matter of training, wouldn't wait until being asked to prepare a report of that kind, would they? The code of conduct, for one thing, would require some level of reporting?

W That's right. It's not only the COPD that would require; they would be obliged under the code of conduct to report that as well.

CA So there is more than one source of obligation?

W Yes, that's correct.

CA And it wasn't followed on this occasion?

W That's correct, that's correct.

CA Of some concern to the investigators was that what's described as a chain of command mentality might have been coupled with a culture of fear and reprisal. Without expressing a final conclusion about that, the inspectors felt that there was some evidence that that was so.

W As I said, I think the inspectors interviewed over 35 people, and they were long interviews as well.

CA With what objective, sorry?

W I think in terms of not only determining what might have led to an incident like this and how it could be prevented, ultimately I think the firm conclusion and advice given to me by the multiple inspectors, and we had an eminent QC involved in the investigation, and so on, was that, look, there is that concern, there's that underlying concern from a number of

staff during this. I think that, yes, there is this underlying concern of following a line of authority, and that could be as innocent as following that line of authority, or it could be also due to fear of reprisal and also could be due to sticking up and sticking together with your mates, if that makes sense.

CA They were the conclusions the inspectors took, that they were of the view that their failure to report was influenced by a fear of reprisal, in some cases, and, in other cases, was motivated by wanting to protect a colleague, so it was both.

W Yes.

CA This is another of these incidents where identification of, to use the inspectors' words, a culture of fear and reprisal might have wider implications beyond the particular centre concerned, might it not?

W Yes.

CA This was a fairly high-profile incident and investigation, was it not?

W That's right.

CA Would this report have gone to the Commissioner and to the various board members for their consideration?

W It would have followed the normal process.

CA But not for consideration, though, at a board meeting as a subject of deliberation?

W No.

CA It would go to board members for such use as they chose to make of it; is that correct?

W That's right.

CA In their discretion?

W In their discretion in terms of otherwise, but also to the extent that any recommendations fall within their portfolio of responsibility, to respond to the incident oversight committee in respect of the specific recommendations. That's basically it.

CA In the ordinary course, would a report such as this be made known to the general manager at Maryborough?

W I'm unaware of that.

CA You may not be aware as to whether that occurred or not, but do you know whether there is a process whereby such a report, as a matter of course, goes back at least to the general manager of the centre concerned?

W Sorry, you mentioned Maryborough. In this instance, the incident occurred at Wolston.

CA Oh, sorry, sorry.

W So I understand it would go back to the general manager. But as to broader distribution, I'm unaware.

CA You are not aware of any system for its broader distribution?

W No, I'm not.

CA You are not aware of any person, board member or otherwise, whose responsibility it is to distill from such a report that there may be a culture of fear and reprisal amongst officers and to consider what implications for the service such a finding might have?

W As I understand, each board member reads the report and considers the report and its implication from their perspectives. For example, the Executive Director, Operational Support Services would do that; the Deputy Commissioner would do that; the General Manager, Strategy and Governance would do that. That's my understanding.

CA I want to turn to something different, Mr ZHOUAND.

W Sure, Mr RICE.

CA It is the official visitor program. Under section 296 of the Act, I am sure you are aware, the Act gives you the function of coordinating the official visitor scheme.

W That's correct.

CA What do you take to be involved with "coordinating", to use the Act's term? It is perhaps open to interpretation?

W Yes, it is. In terms of approaching the official visitor scheme, one of the things that I avoid, and I tell my staff to avoid under all circumstances, is to tell Official Visitors what to make in terms of a finding. If an official visitor substantiates a matter, we don't tell the official visitor not to make any of those findings.

From a coordinating perspective, what we do is we recruit, induct and train official visitors. We schedule them to attend. We provide relevant information, before their attendance, in terms of safety or segregation orders. Where prisoners have come to us and they want to see an official visitor, we refer matters to them.

If they have any issues or problems, they call the state coordinator of the official visitor scheme in my office, and they get advice. To the extent that they can't get it at the centre from staff, they get it from my office in terms of any policies or procedures. Then we also give them feedback in terms of, "Well, we have reviewed a number of your reports. We note that perhaps you could do more here, or you could do more there."

And also where we do find, I suppose, issues on a more thematic sense that the OVs are doing or not doing, we communicate that to them as a collective. We encourage networking. Also, as part of the coordination

of the OV scheme, if OVs make findings and recommendations, we refer that to appropriate BOM members. And to the extent that even when they don't make findings or recommendations, their reports contain a lot of really useful and relevant information, which we use to highlight more thematic system issues, and we advance those, be it in our inspection reports, be it in our thematic reviews or be it in some of our ICRs, which are individual case reviews.

An example might be incentives and earned privileges. Over a period of time, OVs repeatedly either made substantiated findings or, in their reports, even though they didn't substantiate it, they raised and provided information about these issues relating to incentives and earned privileges. So then we were able to systematically review that and then advance that to corrective services, to the Commissioner at the time, highlighting some serious concerns we had about it. Then, I think from memory, that led to particular decisions, and so on. In a broad sense, that's how we do it, but ultimately we don't tell them, in any stretch of the imagination, what to do.

What we do tell them - if we disagree with it, we ask them if they have considered the additional matter in terms of it. For example, for consecutive safety orders, if an OV makes some findings and we find that perhaps the OV hasn't considered the issue of the mental health of the prisoner or appropriately the long-term nature of the prisoner, we go back to the OV, through the OV coordinator, and we say to them, "Have you considered these additional mental health issues, and so on? Would you mind putting your mind to it and coming back to us as to what your final report may be?"

CA "OV coordinator" - is that the expression you just used?

W Yes.

CA Is that one of your -

W That is an AO7 position in my office, that's correct.

CA From all that you have said, do we take it that in the coordinating function that the Act gives you, you see a component of influencing quality of the operation of the scheme?

W Absolutely.

CA The Act gives the chief executive authority to appoint an official visitor. Do you have the delegation to do that?

W I do.

CA In terms of identifying an "appropriately qualified person", how would you determine that?

W There are three categories of official visitors: there is community, there is indigenous and there is legal.

Generally, we advertise in SmartJobs, as well as in Seek, for official visitors. We have, from time to time, advertised in the Law Society

Journal and those types of areas, and we have from time to time deliberately sought out the Law Society or the Barristers Association in terms of perhaps referring people to us.

In terms of indigenous, we also have in the past advertised in the Courier-Mail. We have changed that process a little bit recently, where I think about 18 months ago, two years ago, we consulted with relevant indigenous stakeholders, because we had an issue, and we really knew that it was an issue, in regard to not getting enough indigenous official visitors.

One in particular we consulted was Gallang Place in terms of helping us to find ways to get indigenous official visitors. I have to acknowledge their great contribution. They gave us some great ideas. Out of that came a process, which we implemented I think about 12 months ago, which was effectively - and a way that we are getting a lot more indigenous OVs at the moment is we actually, through the OV coordinator, go to Gallang Place, or I think we have also been up north once, and essentially without advertising or anything like that, those stakeholders tell the relevant members of their community about this potential role. Then people come. We train them up, and if and when they feel comfortable, then they lodge an application and we assess their application. That has helped us, as a way to recruit indigenous OVs, increase that number.

CA Commissioner, is that a convenient time to break?

PO Certainly, Mr RICE. We will adjourn and come back at 10 to 12.

SHORT ADJOURNMENT

PO Mr RICE.

CA Mr ZHOUAND, in response to complaints received by official visitors, typically do they result in some kind of a written report of the complaint and its outcome?

W That's correct.

CA Section 292 of the Act refers to official visitor reports. Just to remind you, it says that an official visitor must give to the chief executive - and in practice, that would be you - if asked, a written report about the investigation.

W That's correct.

CA Is the report to which that section relates the kind of report I have just spoken about?

W That's correct.

CA Do the official visitors need, in practice, to be asked by you or is the system in place such that they would ordinarily prepare some form of a written report?

W The system is in place for a report to be provided as a matter of course for each matter that they review.

CA The Act requires it to be given back to you?

W Yes.

CA What use would you then make of it?

W In terms of that, we have an online system. I should clarify that. Essentially, the report comes to us, and then if it substantiates a matter or if it makes recommendations, or even if it doesn't substantiate the matter or doesn't make recommendations but makes some observations about things that are good or not good, the practice up until now has been that that's put in an email from me to relevant BOM members for their appropriate consideration and action in the circumstances. That's one avenue.

CA Does that operate, by the sound of it, in a rather similar way to your findings in relation to these incident reports that we looked at?

W Those emails have not tended to go to every single BOM member. It goes largely to the Deputy Commissioner, Statewide Operations or either the Executive Director, Specialist Operations or Executive Director, Operational Support Services in respect of private prisons. Where it's sort of like a mental health or rehabilitation issue, it goes to the Executive Director, Specialist Operations.

CA Do you filter that to analyse what's good and not good and report in those terms?

W That's right. They might make a range of findings, observations, and so on. So I have been sending an email to the relevant person. We say, "Whilst facts on the ground may differ, this is how things appeared to the official visitor", and sometimes we will add additional commentary, our observations of this particular concern. But otherwise, each one of those matters - not every single one, but the ones that we think are of concern, and that includes every substantiated matter, that includes ones where there are recommendations, and the ones we add to it, are referred to the relevant BOM member.

Then how it occurs in practice is that that relevant BOM member considers the matter and they might consult with their relevant people, for example, with the relevant prison or the relevant director. Then sometimes they get back to me in terms of, "We agree" or "We disagree", but sometimes they don't. Then it is a matter for them in terms of how they address it. So that's one way in terms of how those issues are progressed on an individual basis.

What we also do is, because we made it online, we're able to review it and say, well, look, we are getting a trend, and then we incorporate that as part of a potential ICR that we use. We use that information also to inform issues we might look at during an inspection as well as use that evidence, I suppose, to form conclusions. For example, when we do investigation reports or inspections, where we do say some things are a system issue, we don't just rely necessarily on that prison-specific evidence we've got. We look at previous reports. One of the other things that we have mind to is, well, what does the official visitor scheme say in respect of that

issue; what have been the recurrent observations or findings or complaints as part of the official visitor scheme?

CA Do you take it on yourself, as part of the coordinating function, to distill the accumulated experience of the official visitor reports for what they might reveal about ways to assist management? Do you see what I mean?

W I see what you mean.

CA You review the reports, but the question is whether they stop with you or whether the value that they might reveal in terms of trends, types of complaints, and so on, is fed back to the management, of which you're not strictly a part.

W Yes. In terms of that, the learnings and issues distilled from official visitor schemes are, I suppose, distilled and referred by us through those emails to relevant BOM members in regard to individual reports. Also, they're distilled and referred by us in terms of the systems issues we highlight and address and advocate for, in terms of resolution, to corrective services.

CA Likewise, the Act actually requires the official visitor to give a report summarising the number and types of complaints that the visitor has investigated?

W That's correct.

CA That applies to each visitor?

W That applies to each visitor. We don't strictly comply with that because of our online system. We have that information, in any event.

CA The number and types of complaints might potentially be of interest to a general manager?

W Yes.

CA Or to the Deputy Commissioner, Statewide Operations. Is there any conduit for making that kind of information known for the use of managers at that level?

W I think that's a good comment and I think that's something we used to do, but I think it has lapsed in recent times.

CA Is that because of any perception of the value of official visitors' reports or for some other reason?

W I think the way we have approached it is to address the issues themselves. The complaint categories are similar to the complaints management system and the numbers correlate with the complaints management system. The general feedback we've had in regard to those types of reports, at least in terms of the complaints management, not the official visitors, is that - I suppose, other than making you aware that perhaps property is an issue or that there is an offender accommodation issue, it doesn't give you any more information as to how to address it.

The way we've determined it so far, in terms of our process, is to highlight

those individual issues, be it through those emails or be it through our ICRs or through our investigations and inspections, which feeds into it.

CA You have described in your own submission to the inquiry the operation of a telephone service by which complaints can be lodged.

W That's correct.

CA Could I just ask you to confirm whether or not the telephone service extends to the making of complaints and discussion of complaints and information gathering, or is it just to make an appointment?

W Sure, yes. It's largely to the latter. Essentially, if a prisoner wants to see an official visitor, legislatively they have to go to a staff member to put them on the official visitor logbook, and then an official visitor goes and sees them, from a legislative sense.

CA So that it's well known that is what is to occur?

W That's right, so prisoners still have that avenue. But when we implemented the online system, and I think it was a number of years ago as a result of that incident at Brisbane Women's in terms of that officer and sexual assault, and those types of things - we did that, and it was slow uptake at first, but then numbers increased and prisoners gave feedback that that was really good that they don't have to go through a staff member; they feel much better.

So then we expanded that out to all centres. Essentially, how it works is that a prisoner calls that number and says, "I want to see an official visitor. My name is X and I'm at this centre." And that's all they have to say. Effectively, what that does then is that that message gets converted into an email, a recorded message that comes to my office, and then the official visitor coordinator arranges for an official visitor to see that prisoner for the next visit. So there is no obstacle in their way in terms of seeing an official visitor.

CA Would it be fair to say that to enable such a visit to occur would have to be with the knowledge and concurrence of a correctional officer in that person's unit?

W I can't go in terms of the specifics of that officer's unit. There may be some circumstances they know. What largely happens is that once the official visitor coordinator receives that information, what we've done - in order to make sure technical compliance with the legislation, the centre general manager's staff are advised and there is a central electronic register that we put the prisoner on. Essentially, that's all that happens. As to how they inform the unit staff, I'm not privy to that. But what happens, I suppose, from our perspective is that the official visitor goes there on the next visit, takes the prisoner's complaint and that leads to different avenues in terms of how that is dealt with there.

CA Is there any time limit, do you know, on time spent with an official visitor?

W In terms of time spent with an official visitor?

CA At the visit where the complaint is discussed.

W Not that I'm aware of. It depends on the individual circumstances.

CA I just want to ask a couple of things about the Official Visitor Scheme Manual, if you don't mind.

W Sure.

CA A copy of that was produced by the Commissioner last week.

W Yes.

CA It is Exhibit 7, if Mr ZHOUAND might be shown a copy of that.

W Thank you.

CA You are familiar with that, I would take it?

W Yes.

CA Something discussed at a couple of portions within it, firstly at page 37, if you could look at that - the paragraphs I am interested in are the third and fourth last on that page. Do you see commencing, "If the complaint is about something within QCS's control"? Just have a read of that to yourself.

W Yes.

CA This is a manual for the guidance of official visitors, isn't it?

W That's right. That is to assist them in performing their functions.

CA At that point, is it not the case that the official visitors are instructed, by virtue of this manual, to, in the first instance, inquire whether the prisoner has made a complaint through the blue letter system?

W That's correct.

CA If not, the official visitor is supposed to tell the prisoner to do so; is that right?

W Essentially, yes, but we do exercise exceptions if it is a serious matter, if the prisoner feels there might be an issue in terms of their safety or a reprisal in relation to it. We've had multiple times or situations where an OV has contacted our office and said that a prisoner does not wish to go to that, and we're totally agreeable with that and we've advised OVs accordingly.

I suppose the issue of getting them to go through the internal complaint system is that I suppose - well, the reason we came to that process was that official visitors are members of the community and they're not totally abreast of all the policies, procedures and processes within the correctional centre. So there might be situations where a prisoner might raise an issue, and the official visitor, I suppose, needs to determine whether corrective services has been afforded an opportunity to address

that for the prisoner, and, if not, the prisoner is referred that way, and then they can come back to the official visitor.

CA Would you accept that one of the reasons why a prisoner might choose to use the official visitor scheme is because of the value of an outside visitor being the one to whom complaint can be made rather than to the hierarchy of the prison itself?

W Absolutely-

CA Do you want to add something?

W What I would add to that is ultimately, I suppose, the view we've taken is that if a prisoner has lodged a complaint or has a grievance, generally speaking the system itself should be given an opportunity to respond to that initially, as a general sense, and there are exceptions, rather than the official visitor scheme automatically saying, "You haven't complied with this. You haven't complied with this", when the system itself wasn't aware about the issue for the prisoner and to be able to resolve it itself, initially.

CA Can I suggest what you describe is made more explicit at page 39, at the bottom of the page, under the heading "Complaint categories". It is quite a specific instruction, isn't it, that official visitors are to tell prisoners that they should "first exhaust their right to make complaint through the QCS complaint management system"? And if they haven't, they're told that's what they should do; correct?

W Yes, as a general principle, so I think-

CA What exception is apparent from that instruction? Is there any?

W I can't tell in terms of that specific paragraph, but I know in other parts of the report we emphasise - the last time I checked, there are sections in the report which say that if a prisoner feels uncomfortable, they can still complain in some circumstances to the official visitor.

But I would just like to add - perhaps "exhaust" is a strong word, but ultimately all it means is that the prisoner needs to go, generally, through the internal complaint mechanism first, and then if they are not satisfied with that, they can go to the official visitor scheme.

CA But do you accept that that might well be the very thing that they are looking to avoid?

W I would imagine that there might be - I can't deny that there can be some circumstances in that situation, but quite often, in our experience, prisoners don't have that much familiarity sometimes with the complaints management process or who to approach.

CA Or they might not have much confidence in it?

W That is correct, or who they might approach or need to approach in terms of staff to talk to.

CA From what you say, notwithstanding how that reads, in practice it doesn't necessarily operate that way; is that what you're saying?

W In practice, there are exceptions in terms of if a prisoner feels that they're - in terms of safety, and they communicate that to the official visitor, the official visitors still take it.

CA Would the extent to which that's so vary according to the attitude and approach of the official visitor, given the nature of the instruction that appears there?

W I'd be speculating about the attitude of each individual official visitor. But from my perspective, there is absolutely no - if a prisoner feels unsafe to go through the internal complaint mechanism, the official visitor scheme does, and should, take that complaint and deal with it appropriately.

CA I was going to ask you how an instruction like that, that we see at page 39, that last paragraph, sits with section 290(1) that is in terms that an official visitor must investigate a complaint made by a prisoner, and it goes on to specify the circumstances. In other words, there is a mandatory obligation on the official visitor, under the legislation, to investigate a complaint appropriately made to him or her.

W Yes, that's right.

CA But at least to a degree, you are filtering, are you not, what complaints are in fact going to be considered by the official visitor?

W The way we've interpreted that provision is that that provision also says there is no obligation to investigate it if it can be referred to another appropriate person or entity. In that situation, I suppose the interpretation we've drawn on it is that if a prisoner in that circumstance lodges a complaint, as a matter of general practice, you give the organisation an opportunity to deal with it first, and if they don't respond to it appropriately, then you independently investigate it and make findings and recommendations in relation to it.

CA I appreciate that in section 290(2) there is an exception on the official visitor's function, excluding that officer from investigating corrupt conduct. But what if a complaint relates to some form of misconduct by a prison officer that doesn't obviously fit the description of corrupt conduct, is that dealt with then at the official visitor level?

W Generally no. We introduced a process a number of years ago where essentially any type of misconduct or corrupt conduct allegation is taken by an official visitor, and the prisoner is not made to go back through the internal mechanism. In those types of situations, the official visitor takes it on a form and obtains some relevant details, to the extent that the prisoner has that.

That gets referred to my office, to the official visitor coordinator, and then, from there - and I should add that, generally speaking, unless the allegation is about any issues about the general manager himself or herself, the official visitor lets the general manager knows that he or she has referred that allegation so as to enable the general manager to implement any safeguards, and so on, from their perspective, if need be.

CA Or redirect it to ESU - is that a possibility?

W Essentially, the general manager doesn't do that. My office does that under this process, so that the prisoner's complaint is independently referred to my office by the official visitor, and my office forwards it on within 24 hours to the Director of Ethical Standards, to the lead inspector at CSIU and to the position of General Manager, Statewide Operations. We leave it for that process to appropriately deal with that matter.

CA One of the functions that an official visitor has - correct me if I am wrong - is to review safety orders?

W That's correct.

CA That can be done - again correct me if I am wrong - if an order is made in the first instance, but the person who is the subject of it asks the general manager to refer it?

W Yes.

CA That's one way. Then whether a consecutive safety order is made, that is an automatic trigger, is it not, to an official visitor review?

W That's correct.

CA Is it any part of your function, as you exercise it, to review the outcomes of reviews like that?

W Again, through our online system which we've implemented, safety orders are reviewed by my office, by the official visitor coordinator. What happens is that if an official visitor recommends that the order be cancelled or amended - and, again, through that earlier communication email system, up until now it's referred to the relevant BOM member, which is the Deputy Commissioner, Statewide Operations for appropriate action.

Then what happens also is that - and, again, similar to the complaints - where they don't recommend cancellation or amendment of the order, even in those situations where an issue is identified by the official visitor, for example, there might be a situation where the prisoner does not get their two hours out of cell, in some circumstances, or it might be whether relevant stakeholders are appropriately, I suppose, assessing the prisoner in some situations, those issues are highlighted. And then, as part of that email correspondence, we refer that to the appropriate BOM members in terms of needing to be addressed or dealt with as appropriate.

Then otherwise, like before, we use that information to individually advance particular matters or issues. We might have a prisoner who - we might find a theme in terms of the way some of these safety orders are conducted, and we send - similar to those memos you referred to me before, we have in the past done some on safety orders in terms of some issues, in terms of them, in terms of legislative compliance issues, and then we also use that information, as we're doing now, because we are embarking on a segregation thematic review, and we also use, I suppose, that range of information to inform that as well.

CA Tell me, in this review function, do the official visitors typically provide

reasons for either confirming, varying or cancelling an order?

W Yes, they do. Could I, Mr RICE, just add to that?

I understand there were something like 500, 513 safety orders that were reported on by official visitors in the last 12 months, and 8 per cent of that was recommended to be cancelled; 4 per cent amendment, and usually with amendment, the recommendation is to reintegrate them back but to have a plan to reintegrate them back.

Then of the remaining, I think 65 per cent were safety orders made on the recommendation of a doctor or a psychologist, largely self-harming, and so on. So the tendency by the official visitors has been to go with the advice of the professional in respect of that.

Again, official visitors, I just want to emphasise - and I think you would have seen that in the multitude of reports we have given to the CCC - a lot of the things they raise, even if they don't find substantiated or - I should correct myself - that they don't recommend be cancelled, we do from time to time refer to those and advocate for those, and so on, and bring them to QCS's attention in terms of some of the issues they raise otherwise.

CA Thanks. That is all I was going to ask you about that.

Probably the final topic is your function with the Ethical Standards Unit. You had not, I gather, until relatively recently, had any function involving the Ethical Standards Unit?

W That's correct.

CA Is that something that has been devolved to you by the new Commissioner?

W That's correct. I understand it is a temporary arrangement whilst there is an organisational structural review going on. I understand, and what has been communicated to me, is that it was felt that it was very important to get ethical standards as a priority in terms of the machinery of government changes and to start some work or preparation on that as early as possible, which we have been doing.

CA Is there some prospect, if not expectation, that with the appointment of several Deputy Commissioners, the function might go elsewhere?

W I honestly don't know. I know the Commissioner has engaged some consultants to conduct an organisational structural review, and it will be really up to them in terms of how they determine which way they go. Ultimately I'll wait on the outcome of that, but, in the interim, what I'm doing is managing the function on behalf of the Commissioner.

CA The Commissioner has made mention of the appointment in the very near future of a manager of that unit?

W That's correct.

CA Is that someone who will operate under you?

W That's right. Essentially, this was one of the things in terms of the Ethical Standards Unit, even though it has come recently, but one of the priorities we had put was the need to get someone highly capable to lead the unit as soon as possible. So we embarked on a recruitment process, which we finalised, and that individual - and I can advise you who that is. His name is Mr Andrew BALLANTYNE and he commences on 4 June in the role.

CA Is there to be any change in its staffing from when it operated under DJAG?

W I think that's really a matter for QCS in terms of their budgeting processes, and so on.

CA You just take what you are given?

W I take what I'm given, but I can advise that there is a need for additional staff, absolutely, particularly in terms of the prevention and proactive staff and in terms of the intelligence aspect of the role.

CA Do you have any view on how it might operate differently from the way it operated under DJAG?

W I can't speak too much about how it operated at DJAG, but I do know that the Commissioner has a strong preference in terms of having a very, very proactive and preventative-focused Ethical Standards Unit. When we did get ethical standards from DJAG, it has been, I suppose, a unit with limited resources and there was a backlog in terms of approximately, I think, 200 matters. In the short time we've had it, we've brought it down to about 95, and that continues to be worked at.

But some key things, I suppose initial things we have identified in terms of it - besides a strong focus on prevention, a lot more proactive training; a lot of communications and engagement with staff; I think having specific ethics officers in each prison, and I suppose liaison officers or coordinators - they would play a key role. The need for a very good and robust case management system - that's missing, because at the moment I suppose a lot of the information is manually inserted on an Excel base, but if you had an appropriate case management database that not only helped you to case manage properly but you could share with relevant key stakeholders, such as the CCC and so on. I suppose it's initiatives like that, and we would also be seeking to engage with relevant research institutions, and so on, to make sure that it is as evidence based and informed by best practice as much as possible.

CA You have a task in front of you.

W I have a task in front of me.

CA You refer in your submission to the delivery of training to, as you phrase it, support and re-educate staff members about their obligations to report wrongdoing. What has been the delivery of that kind of a program?

W I can't go into too much detail, because I don't have the specifics of the DJAG, but in general terms there's ethics training for new recruits. There's online annual refresher training. I think also up until recently, the

ethics unit in DJAG ran what was a tools of the trade training for managers and supervisors across the state. Now that is provided through the academy, so when they have their supervisor or leadership training events, someone from the ethics unit goes there and provides some training in terms of tools of the trade for managers and supervisors. Besides those things, we have created a central phone line and email line, so if people have specific issues, and so on, they can call the ethics unit and they can talk to an ethics consultant, who can advise them on individual matters.

CA In carrying out the investigative function for specific complaints, do you know whether that will be done by staff who are coming across from DJAG who may previously have been carrying out that function?

W That's right. Yes, some investigations will. As part of the transition, we have transitioned some staff from DJAG across to QCS.

CA The proactive function that you described is going to take additional resourcing, isn't it?

W That's correct.

CA It hadn't been a priority in that fashion previously; is that a correct situation?

W I honestly can't speak into the details of how DJAG did it, but I suppose with the function coming to us and having a look at the environment and having a look at the Commissioner's expectations, there is a clear need to do a lot more in regard to prevention and proactive work, and, yes, we will be seeking resources in regard to that.

CA Thanks, Mr ZHOUAND.

W Thank you.

PO Thanks, Mr RICE. Mr MURDOCH?

CM When you were before the Commission last Tuesday, you gave some evidence in respect of utilising the services of inspectors from other states; do you recall that?

W That's correct.

CM In what types of circumstances do you utilise such services?

W I have used predominantly the Western Australian inspectors, because they are, I suppose, pre-eminent, the most reputable in Australia. So I have used them for inspections and investigations and to advise me when we do ICRs, and so on. I engaged them previously, and most recently we did a snapshot inspection of Townsville and we used a Western Australian inspector for that.

CM You also referred, in the course of your evidence last week, to something known as a HASI test; can you recall that?

W Yes, I do.

CM Can you just give a little bit more detail about what you understand that test to entail?

W Sure. The HASI test is essentially a test to determine cognitive impairment - intellectual disability, to be clearer. As I understand - my colleague, the Executive Director, Specialist Operations can better advise of this, but essentially there is that initial process which a person goes through, through reception, that asks four questions. Depending on the answer to that question, it leads to a HASI test, which then determines whether the prisoner has an intellectual disability or not.

CM Also in the course of your evidence last week, you made some reference to a literature review. Do you recall referring to that?

W Yes.

CM What are you referring to there?

W One of the things in terms of - I suppose, from our office's perspective, we just wanted to make sure that as we move forward, any opinions we did form, and so on, and to assist our colleagues in terms of dealing with this important issue of ethics and corruption in decisions they make going forward, that it is based on evidence and literature. So we commissioned a literature review by Flinders University in regard to that.

CM Has the completed final report been provided?

W Yes, it has.

CM Could I just have a document shown to you, please. Just have a look at that, and can you confirm that that is the final report of the literature review that was sought?

W That's correct.

CM I tender that, may it please the Commission.

PO Thank you. That is Exhibit 58.

ADMITTED AND MARKED EXHIBIT 58

CM You also gave some evidence last week in respect of a process whereby there was a follow-up, I think you may have said 12 months after the provision of an inspector's report. Do you recall giving that evidence?

W I do.

CM Can you just give some brief details as to what that follow-up process entails?

W Sure. Essentially, what we do and the process we have applied is that we go approximately 12 months after a full announced inspection to a site. In doing that, we review the documentation and evidence provided by the relevant centre, Statewide Operations, and so on, to determine

whether some of those remediations identified in our report have been implemented. Then based on that report and then the onsite observation, we make a conclusion as to whether it has been fully or partially implemented, or not implemented at all. Then we submit that record, again, to the Commissioner and relevant BOM members accordingly.

CM You gave some evidence earlier today in respect of some particular reports that Mr RICE took you to.

W Yes.

CM One of them involved the use, or the effective use, of body-worn cameras.

W That's correct.

CM There was some mention made in that report in respect of the non-utilisation of vests. Do you recall that issue being raised?

W I can't recall it off the top of my head, but I have no reason to doubt that it was, yes.

CM Do you know what the current status is in respect of the use of vests in QCS with respect to body-worn cameras?

W I can't recall.

CM You have also referred to a couple of bodies within QCS, one of them being the board of management.

W Yes.

CM Can you just clarify, in terms of the roles in the organisation, which positions form part of the board of management?

W Sure. The board of management is chaired by the Commissioner. The relevant members are the Deputy Commissioner; the Executive Director, Specialist Operations; the General Manager, Strategy and Governance; the Executive Director, Operational Support Services; and the general manager for the training academy, Alan BUTLER.

CM You also referred to an entity called the incident oversight committee?

W Yes.

CM To clarify, the members of that are?

W Largely the board of management members.

CM In terms of your role, are you part of the incident oversight committee?

W That's right. I am the chair, and my office provides secretariat support to it.

CM You also were taken by Mr RICE to a report involving an incident that occurred at the Wolston Correctional Centre in August 2015. Do you recall being taken to that report?

W Yes.

CM Are you able to say what, if any, action was taken by QCS in respect of the CCOs involved in that matter?

W I understand some discipline action was taken and, in respect of at least some of them, it led to discipline action involving termination.

CM Lastly, the Commission heard some evidence yesterday from the Australian director of a body called Human Rights Watch.

W Correct.

CM You are aware, are you, that in February 2018 that body produced a report in respect of neglect of prisoners with disabilities in Australia.

W That's correct.

CM Have you, by virtue of your role, read that report?

W Yes, I have.

CM Following reading that report, did you take any steps to investigate or otherwise deal with the matters raised therein?

W One thing I've done, the report was shared with staff in my office and it has informed our learnings going forward as a unit and the types of issues we would be looking at in future - forensically looking at even more in terms of future investigations and inspections.

What I also did - I suppose, for me, the concern was that they were very serious allegations and there was nothing stipulated in the report as to who, what, when, and so on. From my perspective, those matters needed to be addressed and investigated, so I wrote to Human Rights Watch asking that they provide such details to my office and relevant authorities so as to enable those serious matters to be investigated.

CM Could I just show you a copy of a letter, please. Just have a look at that document and identify it, please?

W That's correct.

CM Is that the letter to Human Rights Watch, which you have just given evidence about?

W That's correct.

CM I tender that.

PO Exhibit 59.

ADMITTED AND MARKED EXHIBIT 59

CM Following that letter being sent, did you obtain or receive any response from Human Rights Watch?

W Yes. Following that, I received a letter from Human Rights Watch, I think on Friday just passing. In that letter, they advised me that they cannot disclose any details because their interviews are confidential, but they did say, for my investigation, what types of issues I could look at.

CM I will show you a further document, please. Just have a look at that letter. Is that the response from Human Rights Watch to which you have just referred?

W Yes, that's correct.

CM I tender that.

PO Exhibit 60.

ADMITTED AND MARKED EXHIBIT 60

CM Following your consideration of that response, have you caused any further communication to be sent to Human Rights Watch from your office?

W Yes. I received the letter on Friday. In the last 24 hours, what we have done is yesterday we posted a letter back to Human Rights Watch, which my office emailed to them today, essentially stating that my office thinks that they do a good job, value working with them in the future, but if they could please pass on the contact details of not only my office, which was given to them, as well as the contact details of other relevant bodies, such as the Ombudsman, official visitor details, CCC, the police, and so on - if they could pass that on if people come to them in the future, but also, importantly, to refer those complainants to them, so if they want to contact my office or any of those bodies directly, they can do so.

CM Yes. Could I have this letter shown to you, and can you look at that and just confirm that is the reply to which you have just referred?

W That's correct.

CM I tender that, may it please the Commission.

PO Exhibit 61.

ADMITTED AND MARKED EXHIBIT 61

CM I have no further questions. May it please the Commission.

PO Thank you, Mr MURDOCH. Mr PEVERILL?

DP Commissioner, could I just confirm what time the lunch adjournment might be taken?

PO We normally adjourn at about 1 o'clock, but if you are close to finishing, we will sit on a little bit.

DP I don't expect to take any longer than 1 o'clock.

PO Thank you.

DP Mr ZHOUAND, I am an industrial officer with United Voice. United Voice is the union that has coverage of private prisons in Queensland.

Forgive me if it seems repetitious, but I just want to take you through a few quick things, and then we will move on to some substantive matters. My understanding is that you have been Chief Inspector of Corrective Services in Queensland since 2011; is that right?

W That's correct.

DP The functions that you perform are granted under the *Corrective Services Act (Qld) 2006*?

W That's correct.

DP One can say that they are fairly broad powers in terms of functions that you can perform in that role as Chief Inspector?

W I'm not sure what you mean by "broad powers", but ultimately the powers that are given to me are to conduct inspections, investigations, reviews and coordinate the official visitor scheme.

DP You understand me.

W Yes.

DP For instance, section 294 gives you an opportunity to enter a facility, whether that is - presumably announced. I think that is what counsel took you through last week.

W Yes.

DP United Voice have filed a submission. Are you familiar with that submission?

W I can't recall the specifics of it, but I am aware - I remember reviewing it. I can't recall the specifics, but I can discuss and answer your questions to the best of my ability.

DP Would it surprise you that some of the issues that were raised in that submission were things like understaffing, overcrowding and perhaps some issues around transparency, the integrity of some of the reporting principles in private prisons in Queensland? Would that surprise you?

W I'm not sure about private prisons, but I do recall, as I have communicated during this hearing, that we have done some investigations where we found that there was not appropriate reporting.

In regard to the incidents we looked at, we did a snapshot review of Arthur Gorrie after meeting with United Voice delegates, and in that report we found that there was an issue about overcrowding and safety in the prison.

DP The investigations I presume you are talking about are the snapshot

review 2015, the full Chief Inspector report 2016 and then the further snapshot report 2017?

W Yes.

DP They are the investigations. They haven't extended beyond that, have they?

W No, not in terms of detailed formal reports or anything.

DP You mentioned just a moment ago that you met with United Voice, or certainly there was a delegation of United Voice members.

W Yes.

DP I think last week you mentioned that that coincided with the 2017 investigation report?

W I'm not sure if I mentioned that. I would be speculating. I can't remember in terms of the time specifics.

DP It's possible, though, isn't it, that it coincided somewhere around 2017 that you met with United Voice and that there was a snapshot investigation into the Arthur Gorrie centre?

W I think at the time we had done the full announced inspection, and then we had commenced work on a follow-up inspection. Basically, the advice I was getting from my inspectors was that they were looking good in the follow-up inspection, and then I think this issue arose where there were these serious public allegations about safety issues. Then, at that point, we decided to actually do a snapshot inspection to have a closer look at the safety situation and more generally in terms of Arthur Gorrie.

DP Was that fed back to GEO at any point? Presumably when you do a report, the process would suggest that you go back to GEO or the private prison operator?

W As I understand, my reports largely go through the Executive Director, Operational Support Services, through contract management, and they largely deal with the corporate body in the centre, and so on, yes.

DP So the conduit really is that contract management unit?

W To a large extent, yes.

DP Did GEO provide any response, to your knowledge?

W In respect of which report?

DP The 2017 report.

W Not to my knowledge. I'm not saying that they haven't, but not that I am aware of.

DP Would you expect that they would have provided some sort of response, given the significance of the issues that were raised?

W That's a matter for contract management under their processes, yes.

DP Can I take you to that 2017 report. I am not sure if you have a copy of it, but can I take you to a couple of points in that. On page 44 of 55, there was a 500 per cent increase of serious assaults on prisoners; there was a - I might just wait.

W Sure. Thank you.

DP If I take you to page 44 of that report, there is a title about halfway down the page. Numbered 1, it is referred to as "Assaults and violence", and 1(a) is statistical indicators.

W Yes, that's correct.

DP It then goes to a series of dot points, and at the top of those dot points there is reference to a 500 per cent increase in serious assaults of prisoners-on-prisoners.

W Yes.

DP Then if we move down, assaults prisoner-on-prisoner, a 300 per cent increase.

W That's correct.

DP And then assaults, other prisoner-on-prisoner, a 450 per cent increase.

W That's correct.

DP Then it moves through some other increases.

W Yes.

DP Can I take you to the next page, and this is a question certainly that our membership are curious about and that we think goes to the under-reporting issue. If you look at the next table on page 45 of 55, there is reference to assaults and the second-last column to the right is "prisoner-on-staff".

Presumably, if I move down the first column, that is Arthur Gorrie Correctional Centre, and the prisoner-on-staff assaults are referred to as 2; BCC, 10; CCC, 3; LGCC, 8; MCC, 3; SQCC, 8; TCC, 5; WCC, 6; and WFDCC, 8.

Does it strike you as strange that Arthur Gorrie would only have two reported instances of prisoner-on-staff assault reported?

W Well, I'm not sure if "strange", but I can only tell you in terms of how we interpreted that. We interpreted that in terms of, based on what was advised to us and the evidence we came across, there was that level of incidents, and we took it on face value.

DP Is it possible that that is an unreported number, though?

W It's possible that all of them could be unreported in terms of any centre.

DP If that's the case, is there a process in place where your office satisfies itself about the integrity of that data that is reported? Is there an investigation process that says, "Listen, Arthur Gorrie has two reported prisoner-on-staff assaults. Another prison has ten. In comparison, one is a much larger on-remand facility. The other is a much smaller, perhaps, women's prison"? Is there something that you satisfy yourself with in terms of the integrity of the data?

W Yes, I suppose in terms of the integrity of the data, we review the data, and if we have reasonable doubt about the integrity of the data, we look at it to the extent that we can. But ultimately, largely, when data comes and we review it - and in respect of Arthur Gorrie, we didn't only look at just that matter, as I understand; the statistics revealed we looked longitudinally in terms of the data, and that seemed to be consistent, so we took it on face value.

I note there were allegations of under-reporting, and so on, and we referred that to contract management unit. In terms of determining whether we review every single incident to determine whether there was under-reporting, and so on, we don't do that as an office. We do daily incident checks, but we don't look at every incident. But ultimately we took the data on face value.

DP Is it a regular occurrence, then, that perhaps the contract management unit reports that back up the line?

W As I understand, the Executive Director, Specialist Operational Support Services can advise further, but incident reporting and accuracy is a key contractual performance requirement, and the contract management unit regularly reviews that. From my experience, there have been regular - I wouldn't say "regular", but there have been occasions that I'm aware of that the contract management unit has gone back to the private centres and identified an issue of incorrect reporting.

DP Have any issues come to your attention specifically?

W I can't recall any specific issues.

DP One of the key tenets of United Voice's submission is the question of staffing and putting more staff on the floor. The Act has granted you significant power in terms of corrective services in Queensland. You see a lot of things coming across your desk. If GEO had more staff, GEO being the operator of the privately run Arthur Gorrie prison - if they had more staff on the floor, would this translate to fewer prisoner-on-prisoner assaults or prisoner-on-staff assaults, in your opinion?

CA I object, Commissioner. It is so removed from the area of direct expertise, it is very difficult to see any opinion as having any weight.

PO Mr ZHOUAND, do you think you can make any useful comment on that proposition?

W Mr MACSPORRAN, I don't, and that is one of the reasons why I didn't go into the specific staff ratio or more staff issue in the actual report, but

I did identify the issue of safety as being a significant issue and I highlighted that in my report.

PO Mr PEVERILL, I think Mr ZHOUAND did make that comment in his original evidence, that he couldn't really talk about staff ratios, and so forth, so it is probably a little unfair to pursue it with him.

DP Thank you. I won't pursue that line any further. That's all my questions.

PO Thank you, Mr PEVERILL. Do you have anything, Mr RICE?

CA Just one question.

Perhaps you might take the opportunity to clarify, by reference to tables that appear on page 45, what would be the source of the data that is reflected there?

W The source of the data is IOMS, reporting services. Essentially, incidents are recorded in that as a matter of course. Each incident is required to be recorded. Computers do what they do, and then data is extracted from that through reporting services.

CA Through incident reports or by some other means?

W Through incident reports.

CA Would this data reflect incident reports as recorded in IOMS?

W That's right.

CA Thank you.

PO Thank you. Do you want Mr ZHOUAND excused?

CA Yes, please, Commissioner.

PO Thanks for coming back, Mr ZHOUAND. You are now excused.

W Thank you, Mr MACSPORRAN.

CA Time for lunch, Mr Commissioner.

END OF SESSION

LUNCHEON ADJOURNMENT