DISCUSSION PAPER NO. 4: KEY POINTS

PART A: INTRODUCTION

1. On 28 January 2016 the Commissioner ordered that on or before 10 February 2016 Counsel Assisting circulate to the parties a document identifying the key issues that the Commission is interested in. This is that document.

2. It is important to bear in mind that the Commission's role is fact-finding. This is not adversarial litigation. No charges or claims are being prosecuted. The Commission's role is to ascertain the facts set out in the Commissioner's Terms of Reference (TOR).

3. For that reason, no party should treat this document (or the associated discussion papers) as if they were a pleading or claim.

4. And, it is important to bear in mind that this document is a draft in the sense that it merely reflects some preliminary views of Counsel Assisting (not the Commissioner) based on an incomplete review of the documents and evidence. Other, and different, views may be expressed at a later time. Further documents are being reviewed and both written and oral evidence is to come. That means that the facts are still being ascertained.

5. The Commission's mandate, of course, is governed by the TOR.

PART B: THE LEGISLATIVE & POLICY CONTEXT

6. The decision to close the Barrett Adolescent Centre (BAC) was made against a changing legislative framework. That legislative framework is explained in *Discussion Paper 4A*. Note, in particular, the changes that occurred on 1 July 2012.

7. **An issue that arises is: Who had the legal authority to make the decision to close BAC?**

8. Prior to 1 July 2012, it would seem reasonably clear that a statewide service such as BAC was funded and operated by Queensland Health (QH) on behalf of the State. Thus, a decision to close BAC was within the power of either the Minister or the Director-General of the Department of Health.

9. On or after 1 July 2012, there was a service agreement that governed the relationship between QH and West Moreton HHS (a separate legal entity). Under that service agreement QH purchased from West Moreton HHS certain specified services (local hospitals etc) and, in particular, the statewide service supplied by BAC.

10. Interpretation of that service agreement, and the legislation, is not easy.

11. The policy context comprised a labyrinth of State, Commonwealth and international policies.

12. The policy context is explained in *Discussion Paper 4B* (which will follow in a few days time).

13. **An issue that arises is: Whether that policy framework is accurate and whether any of the policies informed the decisions the subject of the inquiry.**

PART C: THE DECISION TO CLOSE [TOR 3(a)]

Introduction

14. TOR 3(a) requires the Commission to ascertain the facts associated with:

> *"The decision to close the BAC including with respect to the cessation of the onsite integrated education program."*

15. There is conflicting evidence about who had responsibility for the decision, and who made the decision, let alone when the decision was made and for what reasons. Mr Springborg contends that West Moreton HHS made the decision. Dr Mary Corbett, the chair of the West Moreton HHB, contends the decision to close the BAC was made in 2008 with adolescent extended treatment being transferred to a new site to be built at Redlands. She refers to a sequence of events from November 2012 to August 2013 involving both the West Moreton HHB and the Minister. Mr Tim Eltham, the deputy chair of the West Moreton Board, says that the decision was made in the late 2000s when a decision was made to build a new facility at Redlands. He says that the Minister had legal authority to close BAC. Dr Kingswell says that the decision was ultimately made by the Minister but he expects that the decision would have been made in consultation with the Director-General and the West Moreton HHS.[1]

[1] Kingswell at [20(i)].

16. And, the on-site integrated education program did not (technically speaking) close at all; it was relocated.

17. Some witnesses make the technical point that the decision to close the BAC was made in 2008, or shortly after, when there was a decision to move BAC, or when it was subsequently decided that the new home for BAC would be Redlands. Others contend that the decision occurred by early November 2012, and others contend that the decision was made on 6 August 2013, at the time of the announcement of the decision to close BAC. That is something of an arid debate. The decision developed over time. For convenience, the decision-making can be divided into a number of stages.

Stages of the Decision-Making

18. The evidence about the decision-making process can be conveniently divided into these stages:

Stage 1: From approximately December 2008 until April 2012, the BAC was to be replaced by another similar facility. That was in accordance with the *Queensland Plan for Mental Health 2007-2017 and The Outline of the 2007-2008 State Budget Outcomes for Mental Health*. In March 2009 a site at Redlands was purchased at a cost of $1.8 million and by June 2011 approximately $16 million of the projected cost of $18.9 million had been allocated to the capital cost of the project. A model of service delivery had been developed by 2010.

Stage 2: Sometime between May 2012 and August 2012 the Redlands project came to an end and the money allocated to the construction of the project ($16 million or the balance of $14 million) was allocated to other projects, although there is conflicting evidence as to which other projects.

Stage 3: From September 2012 to November 2012 the Department was communicating to West Moreton HHS, an intention to:

(a) continue to develop The Park as a high secure forensic mental health service;

(b) close BAC; and

(c) develop an alternative model of care for the BAC cohort.

Stage 4: From November 2012 to May 2013 there was a process which started with Dr McDermott's 'pre-announcement' of the impending closure of BAC; and then a prompt move by the West Moreton HHS to assure patients, families, staff and the public that:

(a) no decision had yet been made;

(b) West Moreton HHS was collaborating with an expert clinical reference group who would develop a model of care that would be contemporary and evidence based; and

(c) there would be broad consultation prior to a decision.

Thus, in accordance with a 'Project Plan', the ECRG was formed and spent some time meeting and then reporting to the Planning Group, which mostly accepted the ECRG's report, with some modifications. Both reports were considered by the West Moreton HHB on 24 May 2013.

Stage 5: From May 2013 to August 2013 there was a process involving an opaque and possibly conditional decision by the West Moreton HHB on 24 May 2013, and an announcement of the closure of the BAC by the Minister on 6 August 2013 subject to a range of new options to deliver services being available.

Stage 6: From August 2013 to the closure of the BAC in January 2014 there was a steady, inevitable progression toward the closure of the BAC in January 2014 (with a 'flexible' closure date) but with, it appears, little attention given to the West Moreton HHB's conditions for closure or to the development of care alternatives.

19. There are 3 relevant decisions.

20. The first is that on 28 February 2008 the then Cabinet decided to replace BAC with a new unit and allocated funds for that purpose as part of the *Queensland Plan for Mental Health 2007-2017*.

21. The second is that on 3 May 2012, Dr Geppert, Dr Kingswell and Dr Young (Chief Health Officer) issued a briefing note for approval to the then Director-General, Dr Tony O'Connell. The briefing note sought approval from the Director-General to cease the Redlands Adolescent Extended Treatment Unit capital program (the Redlands project) which was the proposed replacement of BAC. That briefing note was signed and thus approved by Dr O'Connell on 16 May 2012.

22. That decision raises these issues:

a. Was that decision legally effective, and what was the effect of the subsequent successful efforts to have the Minister sign another (different) briefing note approving the cessation of the Redlands project (which was signed by the Minister or his office on 28 August 2012)?

b. What were the inputs[2] and reasons for that decision?

c. Was the decision based on the government's budget management strategy (as Dr Cleary contends)?

[2] Note the later discussion of the concept of 'inputs'.

23. The third is that on 24 May 2013 the West Moreton HHB decided (albeit in opaque terms) to close BAC. On 31 July 2013 the Minister's chief of staff signed as 'noted' a briefing note recording the West Moreton HHB's approval of the closure of BAC dependent on alternative appropriate care. The decision was then announced by the Minister on 6 August 2013.

24. That raises these issues:

    a. What were the terms and effect of the West Moreton HHB's decision?

    b. What was the effect of the 'noting'?

    c. What were the inputs and reasons for the decision?

Education

25. BAC included an integrated school. That school did not close but was relocated to Yeronga for 12 months and then to Tennyson. It seems clear from the evidence of Ms Patrea Walton and Mr Peter Blatch that that the decision to relocate the school was made in October 2013, once the decision to close BAC had been announced.

26. Further, in late July 2013 a brief was prepared recommending that the DETE, Mr Langbroek, approve the proposed school closure to be announced in the Government Gazette. That briefing note was not approved and a handwritten note at the end of the document, dated 7 August 2013, records that: "*As QH have not advised of the intended service delivery model we are unable to move on this matter*." Another handwritten note on the document, dated 2 days later, is: "*Noted. Once further advice received, further consideration will be undertaken*".

27. That suggests that DETE's decision was dependent on QH's decision and plans, and that was the case even after the announcement on 6 August 2013.

28. That raises the issue: Did DETE have any role in the making of the decision? (It seems not from the documents presently available to Counsel Assisting.)

PART D: THE BASES FOR THE DECISION TO CLOSE [TOR 3(b)]

29. The TOR calls for an examination of the bases or reasons for the decision to close.

30. The reasons for the decision to close, often conflated with the decision to relocate, appear to fall into the categories set out in *Discussion Paper/Table 4C.*

31. As explained in the table itself, the objective of that table is to list the reasons available in the evidence contributing to the decision to close BAC. There is some subtlety involved. Some of the initial reasons which arose as reasons for the decision to relocate the BAC to Redlands re-emerged as reasons to close BAC. The first 7 reasons appear in the evidence to be reasons for the cancellation of the Redlands project. The later 7 reasons appear in the evidence as reasons for the closure of BAC, on the basis that Redlands had ceased as an option.

32. The table is a work-in-progress and will be informed by the oral evidence.

33. The table raises this issue: what were the reasons for the decision?

PART E: THE INPUTS INTO THE DECISION TO CLOSE [TOR 3(c)]

34. This TOR requires a consideration of the information, advice, processes, considerations and recommendations that related to or informed the closure decision and the decision-making process related to the closure decision.

35. For convenience it is proposed to use the expression 'inputs' as shorthand for "*information, advice, processes, considerations and recommendations*".

36. Essentially the TOR calls for a consideration of the inputs that informed the decision, and a consideration of the decision-making process.

37. The sequence of events leading to the decision is summarised in *Discussion Paper 4C*.

38. The issues that arise are: Is that a reasonable summary of the inputs and process? And, in particular, what role did the Expert Clinical Reference Group (ECRG) and the Planning Group and the West Moreton HHB play in the decision? What role did the expressed views of the stakeholders (e.g. parents and staff) have on the process?

PART F: ALTERNATIVES FOR THE REPLACEMENT OF BAC [TOR 3(g)]

39. The TOR requires consideration of any alternative for the replacement of the BAC that was considered, the bases for the alternative not having been adopted, and any other alternatives that ought to have been considered.

40. There are two possible interpretations of this TOR.

41. The narrow interpretation is that the TOR requires a focus on a replacement of BAC with a similar in-patient or subacute facility. On this narrow interpretation, the only replacement facility considered was the proposed new facility at Redlands. No other facility seems to have been seriously considered. In fact, the sequence of events demonstrates a 'Redlands or nothing' approach. No other investigations appear to have been undertaken.

42. This raises the issue: What alternatives were considered and what should have been considered?

43. The wider interpretation requires a consideration of whether BAC might have been replaced by any one or more of a wide combination of models of care.

44. This requires a consideration of the precise models of care that were available when BAC closed in January 2014 as well as whether those models were appropriate for the BAC cohort. There is a temporal element here. The models of care available in January 2014 have been developed subsequently. Indeed, there is some evidence that the BAC cohort was intended to be accommodated in interim arrangements until new models of care were established and became available. More on that aspect later.

45. The first step is to understand the models of care that are either offered or are to be offered. The continuum for the models of service are being developed by CHQ HHS for adolescents with severe and persistent mental health problems pursuant to the Statewide Adolescent Mental Health Extended Treatment Initiative (AMHETI).[3]

46. Commission staff have prepared a draft table, for present purposes labelled *Discussion Paper/Table 4D*. A copy is attached. That document is a working draft.

47. That table summarises the features, service elements, age ranges, client profiles, exclusions, length of stay, locations and other features, of each of 6 models of service. Some of those models are existing, some are expanded from existing services, some are new, and some are proposed.

[3] The AMHETI program was formerly the SWAETRIS Project Plan; see ex C to Ms Adamson's statement at 30-56.

48. That table raises this issue: Is that a fair summary of the models of service available and being developed by CHQ pursuant to the AMHETI program, and are there other or different models of care being developed?

49. To make matters a little more confusing, there are some services which appear outside the AMHETI program. For example, the Townsville Adolescent Inpatient Unit and Day Services were not one of the newly planned and developed AMHETI services.

50. And, as it happens, only one former patient of BAC transferred directly to a new AMHETI service, and that patient does not appear to be a transition patient under the TOR.

51. The second step is to assess what models of service were available to the BAC cohort both before the closure of BAC and after its closure.

52. That has also been recorded, to the extent that it can be at this stage, in a *Discussion Paper/Table 4E*. That table records, again on a draft basis, the adolescent mental health services in Queensland at 4 different points of time:

    a. Prior to the closure of BAC;

    b. At the end of January 2014 – when BAC closed;

    c. As at 31 December 2014; and

    d. Current (i.e. as at the end of January 2016).

53. The evidence available to the Commission so far suggests that:

    a. Only one new service became operational in the period immediately after BAC closed – Greenslopes YRRU (Youth Resi) became operational in February 2014;

    b. The first 3 AMYOS teams did not come online until July 2014 and then progressively more came on line until December 2015;[4]

    c. There were 2 subacute beds (called swing beds) at the Mater acute unit which were available as at late January 2014 and then 4 subacute swing beds available at the

[4] See the evidence of Dr Stathis and Ms Krause.

LCCH acute unit from December 2014, but there have only been 2 subacute patients who have used those 'swing' beds.

54. And so the issue arises: Is *Table 4E* a reasonably accurate picture of the services available to the BAC cohort as at those 4 dates?

55. The third step is to assess what the opinions of the expert child and adolescent psychiatrists as to the need for extended inpatient treatment.

56. The ECRG reported on this issue on 8 May 2013.

57. The Commission has sought the views of a number of experts, some of whom were on the ECRG.

58. And so the issue arises: what are the expert views as to the need for extended inpatient treatment? There are also two related issues: what is the profile of the patients who require extended inpatient treatment; and is it clinically appropriate to 'mix' acute and subacute patients as the 'swing' bed model assumes?

PART G: TRANSITION ARRANGEMENTS FOR TRANSITION CLIENTS [TOR 3(d)]

59. TOR 3 (d) introduces the concept of "transition clients" and requires the Commission to ascertain the facts associated with:

> *"for BAC patients transitioned to alternative care arrangements in association with the closure or anticipated closure, whether before or after the closure announcement (**transition clients**):…".*

60. The language used requires some 'association' between the particular patient's transition from the BAC to alternative care arrangements, and the closure or anticipated closure. That 'association' does not require that the transition be solely or only related to the closure. There may be an association because, for example, the likely closure was one of a number of factors which influenced the clinical staff to recommend transition to another facility.

61. As identified above, one of the key issues the Commission is interested in, is when the closure decision was made. The evidence is that whilst the formal announcement of the decision to close BAC was made on 6 August 2016, the likelihood of the centre closing was foreshadowed as early as 2 November 2012 to medical staff, and to the public, including staff, BAC patients and their families, from 8 November 2012.

62. **An issue that arises is: How this knowledge may have informed and affected decisions about the ongoing treatment of the BAC Patients at this time.**

63. The Commission's investigations include a review of BAC patients from October 2012 to closure. A list has been prepared with the assistance of both the West Moreton HHS and QH, and contains the names of 42 young people. These young people include those who were admitted as either inpatients, outpatients or day patients at BAC, those who had successfully been placed on a waiting list and those who were still waiting to be assessed to be placed on such a waiting list. Some of these young people may or may not fall within the TOR 3(d) definition of "transition clients", depending on whether the 'association' referred to above can be found in the evidence.

64. **An issue that arises is: Who are the transition clients?**

Meaning of Transition

65. The TOR and the evidence refer to the expression 'transition' 'transitioning' and 'transitioned'.

66. **An issue that arises is: What is meant by transition (in the context of mental health)?**

67. The '*Ipsos- Eureka Social Research Institute Final Report-Attachment 6: Literature Review*' refers (at page 2) to the most widely cited definition of 'transition' in the literature to be that developed by Blum, Garell, Hodgman and Slap (1993) as follows:

> "*the purposeful, planned movement of adolescents and young adults with chronic physical and medical conditions from child-centred to adult oriented health care systems*".

68. A copy of the Ipsos-Eureka Report has been made available in each parties' legal representatives' data room.

69. The transition of BAC patients (at some stage), whether back to their families or otherwise into the community, or to another adolescent mental health service, or in some cases, to an adult mental health service, appears to have been an aspect of their care and management at BAC. Transition in that sense appears to mean moving patients from one service to another for clinical reasons, based on individual patient assessments. Both the evidence and the literature that the Commission has reviewed suggests that this period of transition is a known risk factor for mental health patients and can bring about periods of vulnerability.

70. Copies of the literature consulted by Commission staff have been made available in each parties' legal representatives' data room.

71. The consideration of the transitioning of BAC patients as required under TOR 3(d), is arguably a more complex one, given that in some cases, it may be considered as an administrative process and not a medical one, on the basis that it occurred because the BAC was to close, and not for clinical reasons. On one view, what occurred was not a "transition" as that expression is usually understood, but in fact a deinstitutionalisation, or the emptying out of an entire extended–treatment adolescent inpatient unit. There appears to have been no relevant literature or guidelines available at the time. Transition in this context was unprecedented.

72. **A number of issues arise including:**

a. **What were the established guidelines/ practices for transition planning, transition management and transition implementation at the BAC (in a general sense historically) but with particularly focus on the 2012/2013 period (under Dr Sadler and then Dr Brennan).**

b. **Was transitioning in the context of the closing of the BAC, a different concept and process from the usual? For example, before any transition could commence, was extra planning required; should formal guidelines have been developed; was a detailed evaluation and assessment of the available replacement services needed?**

c. **What if any resource materials were available to staff engaged in transition planning/ management/implementation?**

Transition Arrangements

73. TOR 3(d)(i) and (ii) require the Commission to ascertain the facts associated with:

> "i. how care, support, service quality and safety risks were identified, assessed, planned for, managed and implemented before and after the closure (**transition arrangements**); and
>
> ii. the adequacy of the transition arrangements;"

74. Further, TOR 3(h) requires the Commission (without limitation) to ascertain the facts associated with:

> "the information, material, advice, processes, considerations and recommendations that related to or informed the transition arrangements and other matters referred to in paragraph (d)…"

75. The responsibility of implementing the transitioning arrangements appears to have rested with West Moreton HHS with oversight from its Board, with the development of new services being led by Children's Hospital Queensland HHS. The performance of these two possibilities seem to have occurred in isolation, even though the various groups involved in the development of new services were expressly charged with developing services to ensure continuity of services for the BAC cohort.

76. As a result, what has emerged is a process which involved the transition of patients to whatever services were available at the time, rather than to new evidence-based services recommended by the ECRG in anticipation of the closure.

77. There is some evidence of a plan by the West Moreton HHB in or about 24 May 2013, to bring in a senior clinician to support the transition and closure. It is unclear from the evidence what happened to that plan. Certainly, a senior clinician, Dr Anne Brennan was temporarily appointed, on a part-time basis to act as clinical director of the BAC from 10 September 2013, after Dr Sadler was stood down whilst [it is said] complaints about clinical governance associated with the BAC were investigated.

78. Whilst a handover between Dr Brennan and Dr Sadler was promised, it appears that no handover was allowed and certainly not facilitated. Dr Brennan was not told that on accepting the role as acting clinical director, she would be required to both devise and implement transition plans. She assumed from a number of conversations, including with those appointing her, that the transition process was already in place and her role would be to look after the patients until they had moved to new services.

79. It is not entirely clear why, but there is a dearth of evidence at least in any formal sense, of any process in place for the transitioning of BAC patients, until Dr Brennan took over from Dr Sadler.

80. It is apparent from the minutes of the second meeting of the SW AETRI Steering Committee dated 9 September 2013 that the role of the BAC Transition Working Group (which was first discussed at the first meeting of this committee on 26 August 2013) was to guide and oversee the progress of safe consumer transition planning and not to develop individual consumer discharge/transition plans. On 23 September 2013, it seems that this

working group changed both in name and function. The first name change was to the BAC Consumer Transition Panel and then to the BAC Clinical Care Transition Panel. This Clinical Care Transition Panel was chaired by Dr Brennan with nominated BAC staff and West Moreton HHS staff as members, and was tasked with developing the individual transition plans.

81. When Dr Brennan took charge, it appears she was forced to go back to basics, including flicking through the telephone book in order to locate existing services that may have been suitable to the BAC patients she was required to transition. As soon as she could, Dr Brennan formed a transition group and a number of other working groups and, with assistance from a number of dedicated, tireless (and in many cases concerned) staff, immediately went about developing and implementing transition plans. There appears to be some conjecture about timing, but the evidence suggests that the BAC was to close by the end of January 2014, with some (unidentified) flexibility. The evidence is that Dr Brennan and a number of BAC staff worked around the clock at times in order to meet the imposed timeframe.

82. On any view, the orchestration and implementation of the transition arrangements in the circumstances was a mammoth, unprecedented and some might say, impossible, task. The overwhelming evidence is that Dr Brennan and the BAC staff tried their very best in extraordinary and emotional circumstances.

83. The BAC closed its doors for the last time on 31 January 2014, at which time the evidence suggests that any responsibility for the care, support, service quality and safety risks of the transition clients ceased. It appears that the view was taken that, as the BAC no longer existed, there was no need for a follow up. However the evidence shows that there were many of those involved in the transitioning, including Dr Brennan and a number of nurses, who considered that, as was the usual practice, follow up was the responsibility of the clinical staff who had assumed the responsibility for ongoing care of the patient. They considered they had a personal obligation to contact receiving services and, indeed, took steps of their own initiative to do so. In many cases, they were told by receiving service staff not to interfere with the patients.

84. **A number of issues arise from this general overview of the factual matrix, including:**

    a. **The apparent lack of coordination between West Moreton HHS and Children's Hospital Queensland HHS;**

b. **What was done to guide and oversee the progress of transition planning?;**

c. **How were individual transition plans developed and implemented?**

d. **What happened to the plan to bring in a senior clinician to support the transition and closure (apparently foreshadowed in or about 24 May 2014)?**

e. **The circumstances of Dr Sadler being stood down. This includes the communications made to the public, staff, families and patients in relation to his departure. Why was there no handover between Dr Brennan and Dr Sadler? Why when the BAC was about to close, was Dr Sadler's standing down considered to be the best/ only option? Were other options were considered?**

f. **What (if any) planning for the transition was done before the announcement of the closure decision; and between the announcement of the closure decision and Dr Sadler's departure?**

g. **Why was Dr Brennan not told that she would be responsible for the planning and implementation of the transition arrangements?**

h. **Should a planned follow up of transition clients have been put in place in the circumstances? If so, by whom?**

i. **Were there sufficient existing services available for the transition arrangements to have been carried out adequately?**

j. **What time frames were imposed for the closure of the BAC and were they reasonable in the context of the transition arrangements?**

k. **Did the (apparent) fact that there were no new or replacement services available until after the BAC closed mean that the transition of BAC patients to existing services was a higher risk than ought to have been assumed?**

Adequacy of the transition arrangements

85. As identified above, the Commission is tasked with inquiring into the "*adequacy*" of the transition arrangements. In other words (with reference to the Oxford dictionary definition), this means assessing whether the arrangements were sufficient or satisfactory.

86. The assessment can only be made after a full and careful analysis of how care, support, service quality and safety risks were identified, assessed, planned for, managed and implemented. It cannot be done in isolation. It must be considered in the context that the transition arrangements relate to one of the most vulnerable groups in society, that is, adolescents with severe and complex mental health issues.

87. A full and careful analysis of the transition arrangement for each and every young person who is potentially a transition client within the TOR is underway and ongoing. If particular inadequacies with respect to individual transition clients are identified during this process, these issues will be raised accordingly.

88. In the meantime, a number of themes have emerged from the Commission's review of the evidence to date which are relevant to the factual inquiry into the adequacy of the transition arrangements (as well as TOR 3(e) and (f), which are discussed in more detail under their relevant headings below).

89. The overriding theme is that the transition arrangements were carried out amidst a backdrop of extraordinary and heightened emotions that reached a crescendo at the time of the announcement of the closure. There is ample (and at times, conflicting) evidence from BAC staff (allied health, clinical and education) and from the families of former BAC patients and the patients themselves, that reveals confusion, uncertainty and anxiety surrounded the circumstances and conditions upon which the BAC would be closed.

90. For example, the early communications from West Moreton HHS to the families, patients and staff in November 2012 were that no final decision had been made and that adolescents requiring longer term mental health care will continue to receive the care that was most appropriate to them.[5] In May 2013 they were told that no decisions would be made about BAC until after all the recommendations of the ECRG have been carefully considered.[6] In August 2013 the announcement was made in terms that the patients would be supported to other contemporary service options that best meet their individual needs.[7]

91. The uncertain future of the BAC over the preceding years, from about the time of the decision to cease the Redlands project in approximately May 2012, seems to have resulted in a change in the staff structure of the BAC. Particularly in terms of the clinical staff, there were inexperienced staff who were less known to the patients and who in

[5] Fast Facts 1
[6] Fast Facts 5
[7] Facts Facts 6

some cases, had no previous experience with adolescent patients. This loss of experienced clinical staff can be attributed, in some cases, to uncertainty of tenure.

92. Families, staff and patients of the BAC provide a variety of accounts as to what they were told about why Dr Sadler had suddenly departed and why he was absent at such a crucial time. Some staff say they were instructed that they were not allowed to have any further contact with Dr Sadler, with repercussions for their jobs if they did. The evidence is that Dr Sadler's removal in the circumstances, only added to the brewing pot of abandonment, mistrust and uncertainty that existed amongst many of the BAC staff, patients and their families at the time. There is also evidence of an increase in acuity of patients during this time.

93. Simultaneously, for reasons that will hopefully become clearer during the course of the hearings, there seems to have been a breakdown of the previous conciliatory and collaborative relationship between the education staff, and allied health and clinical staff at the BAC.

94. **A number of issues arise from this general overview of the factual matrix, including:**

a. **The (apparent) uncertainty about the future of the BAC leading up to the closure decision and its impact (if any) on the transition arrangements;**

b. **The impact (if any) of the lack of experienced and long-term BAC staff on the transition arrangements;**

c. **The impact (if any) Dr Sadler's departure had on the planning and implementation of the transition arrangements;**

d. **Did the (apparent) breakdown in the relationship between the education staff and allied health and clinical staff have any impact on the transition arrangements?**

Kotzé and Skippen Report

95. On 14 August 2014, following the deaths of three former BAC patients, the Director-General of QH appointed Associate Professor Beth Kotzé as a health service investigator together with Ms Tania Skippen and Ms Kristi Geddes, to investigate and report on matters set out in the Terms of Reference as follows:

"*The functions of the health service investigators are to:*

3.1. investigate the following matters relating to the management, administration and delivery of public sector health services:

3.1.1. Assess the governance model put in place within Queensland Health (including the Department of Health and relevant Hospital and Health Services, including West Moreton, Metro South and Children's Health Queensland and any other relevant Hospital and Health Service) to manage and oversight the healthcare transition plans for the then current inpatients and day patients associated with the closure of the Barrett Adolescent Centre (BAC) in January 2014 of the BAC post 6 August 2013 until its closure in January 2014;

(a) Advise if the governance model was appropriate given the nature and scope of the work required for the successful transition of the then patients to a community based model;

3.1.2. Advise if the healthcare transition plans developed for individual patients by the transition team were adequate to meet the needs of the patients and their families;

3.1.3. Advise if the healthcare transition plans developed for individual patients by the transition team were appropriate and took into consideration patient care, patient support, patient safety, service quality, and advise if these healthcare transition plans were appropriate to support the then current inpatients and day patients associated with the closure of the Barrett Adolescent Centre (BAC) in January 2014;

3.1.4. Based on the information available to clinicians and staff at the time of closure of the BAC, advise if the individual healthcare transition plans for the then current inpatients and day patients associated with the closure of the Barrett Adolescent Centre (BAC) in January 2014 were appropriate. A detailed review of the healthcare transition plans for patients who have been associated with serious adverse events should be undertaken."

96. **An issue that arises is: Why the terms of reference were drafted the way they were, and who gave the instructions to do so.**

97. **A further issue that arises is: Why were the Terms of Reference drafted such that they limited the investigators to matters pre-January 2014?**

98. A report entitled "*Transitional Care for Adolescent Patients of the Barrett Adolescents*" authored by Professor Kotze and Ms Skippen was subsequently delivered to QH on 30 October 2014 (**Report**). The Report concluded amongst other things that:

a. the health care transition plans developed for individual patients were adequate to meet the needs of the patients and their families; and

b. the transition plans for individual patients were appropriate and took into consideration patient care, patient support, patient safety and service quality.

99. **An issue that arises is: What (if any) weight should be given to the Report? For example:**

a. **the investigations were carried out in a relatively short time frame;**

b. **only 6 patients were reviewed in detail;**

c. **no patients, families or education staff were interviewed; and**

d. **no staff from the services that received the transition clients following the closure of the BAC were interviewed.**

PART H: SUPPORT TO TRANSITION CLIENTS AND THEIR FAMILIES [TOR 3(e) & (h)]

100. TOR 3(e) requires the Commission to ascertain the facts associated with:

> "*the adequacy of the care, support and services that were provided to transition clients and their families;*"

101. Further and relevantly, TOR 3(h) requires the Commission (without limitation) to ascertain the facts associated with:

> "*the information, material, advice, processes, considerations and recommendations that related to or informed the transition arrangements and other matters referred to in paragraph (d)-(g) above;*"

102. This means that the Commission must inquire into:

a. the care and the support and the services that were provided to the transition clients; and

b. the care and the support and the services that were provided to the families (of the transition clients);

103. This means a factual inquiry must be made as to:

a. what (if any) care; what (if any) support; and what (if any) services were provided to the transition clients and their families; and

b. the impact and consequence of any such care; the impact and consequence of the support that was given; and the impact and consequence of any such services upon the transition clients and their families.

104. The concepts of care, support and services are not defined in the TOR, nor do the TOR identify who might have been obliged to provide the care and support and services to the transition clients and their families. The Commission considers that the reference to care, support and services cover matters that affect the health, safety and welfare of the patients and their families. The likelihood is that the responsibility for providing care, support and services lay with those charged with both the oversight and implementation of the transition arrangements.

105. Given that a consideration of the adequacy of the transition arrangements for the transition clients under TOR 3(d)(ii), requires a consideration of the care, support and the services given to the transition clients, the Commission considers that the focus of TOR 3(e) is on the families of the transition clients.

106. The evidence from former BAC patients and their families is of mixed messages being given about the future of the BAC from in or about early November 2012. In some instances, BAC patients were the ones telling their parents about the proposed closure. Whilst BAC staff did make contact with families, there appears to have been a great deal of uncertainty about the date of the actual closure. Certainly, at least up until May 2013, the assurances were that there would be no closure of the BAC until new services were in place.

107. The evidence is that the consultation with the families about the transition plans varied. Membership of parents on the transition panel was on a case by case basis; some received family visits and telephone calls from Dr Brennan and case co-ordinators. Further the information provided to parents about the transition plans again, varied.

108. There is evidence of arrangements being made for some families to have access to counselling to assist with any concerns about the BAC closure, through for example, the Consumer Advocate at the Park Ms Beer.

109. Once the BAC closed, there is very little evidence of any formal processes of follow up of both the transition clients and the families. Once the BAC closed, the care, support and access to services seems to have become the responsibility of the individual families or receiving services.

110. **A number of issues arise including**:

a. **What was the cause of the confusion and anxiety amongst some of the transition clients and their families leading up to the closure of the BAC?**

b. **What formal processes were put into place to provide care, support and services to these families?**

c. **To what extent were families consulted about the transition plans?**

d. **Were written transition plans provided to families?**

e. **What were families told about the availability of new services both before and after the BAC closed?**

f. **Was there a process or plan for following up transition clients and their families after the closure?**

g. **Who was responsible for any follow up?**

PART I: SUPPORT TO BAC STAFF [TOR 3(f) and (h)]

111. TOR 3(f), requires the Commission to ascertain the facts associated with::

> "*the adequacy of support to BAC staff" in relation to the closure and transitioning arrangements for transitioning clients".*

112. This inquiry requires an investigation into:

a. whether support was given to staff; and

b. if so, what support was given; and

c. the impact and consequences of the support that was given.

113. The investigation of these issues cannot be done in a vacuum. In other words, you cannot properly examine and assess the adequacy of the support given to staff without looking at the impacts and consequences of a particular type of support or an alleged lack of support. The support issues cannot be sensibly divorced from the consequences of support or lack of support.

114. The concept of support is not defined in the TOR. Nor do the TOR identify who might have been obliged to give support to the staff of the BAC.

115. The categories of support are not closed and are not necessarily confined to the formal legal workplace obligations owed by an employer to an employee.

116. This TOR appears to cover matters that affect the health, safety or welfare of the staff. For example, the staff may not have been supported if they were not adequately trained or not adequately supervised, or if their work burden was too onerous or if they were subjected to unreasonable pressure or stress in what was otherwise a very difficult job.

117. In summary, the Commission's investigation of the adequacy of support for staff requires the Commission to not only consider the fact of support (or not) but also to consider the impacts or consequences of the support or lack of support. Some staff may have received no support but that may have had no impact on their service delivery or on their own health. Others may be in the opposite situation. Both are within the scope of the Commission's factual investigations.

118. There is ample evidence from the allied health staff, education staff and indeed clinical staff who were employed at the BAC from 2009 until it closed. Even a cursory review of this evidence reveals an environment of confusion and anxiety and concern leading up to the closure of the BAC. There was a concern not only for their own future, but a concern for the wellbeing of the young people for whom they cared.

119. **A number of issues arise including:**

a. **General overview of the staffing structure of the BAC particularly over the years 2009 onwards – why, when and how any changes occurred;**

b. **What advice was given to BAC staff (including education staff) during 2012 and 2013 in relation to the proposed closure of the BAC; the closure announcement and the actual date for closure?**

c. **What was the cause of the confusion and anxiety amongst some of the BAC staff leading up to the closure of the BAC?**

d. **How did Dr Sadler's departure impact upon the BAC staff?**

e. **What formal processes were put into place to provide support to these BAC staff?**

f. **Did the decrease in permanent staff disrupt BAC service delivery and continuity of care and impact upon patients' therapeutic recovery process?**

g. **Did staff involved in the transition arrangements feel rushed and under pressure?**

h. **How was the contention that the BAC model of care was not a contemporary model of care raised/ addressed with the BAC staff (including education staff) who had been working under this model for years? Were they consulted?**

i. **What were the purposes of the staff communiques? Did these communiques assist or confuse staff?**

j. **What support and guidance were BAC staff offered to assist in the planning of their future once the BAC closure announcement was made?**

k. **How were BAC staff assisted to deal with the stress?**

l. **Was there any follow up support for BAC staff after closure, and in particular, in relation to the deaths of the three former BAC patients?**

m. **How were staffing issues relating to BAC staff during its closure and the transition process dealt with, and by whom?**

n. **Have any staff suffered any stress related illnesses in association with the closure and/or transition arrangements?**

PART J: ANY CONTRAVENTIONS OF ACTS [TOR 3(g)]

120. This TOR requires the Commission to identify whether any contraventions of the *Mental Health Act 2000*, or other Acts, regulations or directives have occurred with respect to patient safety and confidentiality.

121. This TOR is extraordinarily wide. It could conceivably cover any breach by a patient of traffic regulations.

122. The Commission proposes to read the TOR as requiring an examination of any significant breaches.

123. Thus far the Commission has not identified any significant breaches.

PART K: ANY RECOMMENDATIONS [TOR 4]

124. The Commissioner may make recommendations arising out of the evidence, considerations or findings of the inquiry in relation to the matters set out in paragraphs 3(a) to (i).

125. It is premature to address what recommendations the Commissioner should make.

Paul Freeburn QC

Catherine Muir