BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY
SUBMISSIONS OF DR WILLIAM KINGSWELL

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SUMMARY OF SUBMISSIONS

1. These submissions are made on behalf of Dr William Kingswell.

2. Submissions are made with respect to Terms of Reference (a), (b), (c), (d), (e), (g) and (h). No submissions are made with respect to Terms of Reference (f) and (i).

3. It is submitted that this Commission should find that:

   - the decision to cease the redevelopment of the Barrett Adolescent Centre at Redlands was made by the Minister for Health, the Hon Lawrence Springborg, on 28 August 2012;
   - the decision to close the Barrett Adolescent Centre (**Closure Decision**) crystallised on 15 July 2013, when the Minister for Health gave his support to the decision of the West Moreton HHS on 23 May 2013 "*to support the proposed closure of BAC*"; and
   - the advice provided by Dr Kingswell with respect to each of these decisions was sound and orthodox.

BACKGROUND

The Barrett Adolescent Centre

4. The Barrett Adolescent Centre was a 15-bed adolescent inpatient mental health facility that operated at Wacol between 1983 and 2014. During the period of its

operation, the Barrett Adolescent Centre was gazetted as authorised mental health service in accordance with section 495 of the *Mental Health Act 2000* (Qld).

5. From 1983 to 1989, the Medical Director of the Barrett Adolescent Centre was Dr Cary Breakey. From 1989 to 2013, the Medical Director of Barrett Adolescent Centre was Dr Trevor Sadler.

Dr Kingswell

6. Dr Kingswell graduated from the University of Queensland with a Bachelor of Medicine, Bachelor of Surgery in 1985. He became a Fellow of the Royal Australian and New Zealand College of Psychiatrists in 1997. In 2012, he completed a Masters of Public Health at the University of Queensland. In 2014, he became a Fellow of the Royal Australasian College of Medical Administrators.

7. As can be seen from his CV, Dr Kingswell has particular experience and expertise in forensic mental health. He has written, presented and taught extensively in that area and worked for many years in the area, including at The Park facility itself for many years. [1]

8. From 1 January 2012 to 5 June 2014, Dr Kingswell held the position of Acting Executive Director of the Mental Health Alcohol and Other Drugs Branch (**MHAODB**).

9. From 6 June 2014 to 31 December 2014, Dr Kingswell held the position of Executive Director of the MHAODB, a position which he holds today.

10. Dr Kingswell was the Director of Mental Health from 28 September 2013 until 30 June 2015. [2]

Relevant legislative framework

11. In order to understand how the Closure Decision was made, it is necessary to explain the legislative framework established by the *Hospital and Health Boards Act 2011*

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1 Kingswell, [2]; Annexure 1

2 The Director of Mental Health is a statutory role given to an employee of the Department of Health. The Director of Mental Health did not monitor the delivery of mental health services from the Barrett Adolescent Centre because that falls outside the responsibility of the Director: Kingswell, [1], [6], [30]; Groves, [9]-[11].

(Qld), as well as the "*Service Agreements*" entered into by Queensland Health and the West Moreton Hospital and Health Service.

Overview of the Hospital and Health Boards Act 2011 (Qld)

12. The *Hospital and Health Boards Act 2011* (Qld) (**Act**)[3] makes provision for the delivery of public sector health services and other health services in Queensland.[4]

13. The Act received Royal Assent on 28 October 2011 but the majority of its provisions entered into force on 1 July 2012.[5]

14. The object of the Act[6] is to:

> *establish a public sector health system that delivers high quality hospital and other health services to persons in Queensland having regard to the principles and objectives of the national health system.*

15. Section 5(2) of the Act provides that this object is to be achieved by "*strengthening local decision-making and accountability, local consumer and community engagement, and local clinician engagement*" and by "*providing for Statewide health system management including health system planning, coordination and standard setting.*"

16. Section 7 of the Act makes provision for Hospital and Health Services as follows:

> *(1) Hospital and Health Services are statutory bodies and are the principal providers of public sector health services.*
>
> *(2) Each Hospital and Health Service is independently and locally controlled by a Hospital and Health Board.*
>
> *(3) Each Hospital and Health Board appoints a health service chief executive.*

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3 The Act was originally titled the *Health and Hospitals Network Act* 2011 (Qld).

4 See long title to the Act.

5 See Endnotes to the Act. Note, the Act has been amended on several occasions since 1 July 2012. Two versions of the Act may be relevant to this Commission: the version that is current between 20 May 2013 and 30 June 2013, and the version that is current between 1 July 2013 and 28 September 2013. The 1 July 2013 version of the Act is used for the purposes of these submissions

6 Act s 5(1).

> *(4) Each Hospital and Health Board exercises significant responsibilities at a local level, including controlling—*
>
> *(a) the financial management of the Service; and*
>
> *(b) the management of the Service's land and buildings; and*
>
> *(c) for a prescribed Service, the management of the Service's staff.*

17. The management of the public sector health system is set out in s 8:

> *(1) The public sector health system is comprised of the Hospital and Health Services and the department.*
>
> *(2) The overall management of the public sector health system is the responsibility of the department, through the chief executive (**the system manager role**).*
>
> *(3) In performing the system manager role, the chief executive is responsible for the following—*
>
> *(a) Statewide planning;*
>
> *(b) managing Statewide industrial relations;*
>
> *(c) managing major capital works;*
>
> *(d) monitoring Service performance;*
>
> *(e) issuing binding health service directives to Services.*
>
> *(4) The way in which the chief executive's responsibilities are exercised establishes the relationship between the chief executive and the Services.*
>
> *(5) The relationship between the chief executive and the Services is also governed by the service agreement between the chief executive and each Service.*

18. Section 9 provides that Hospital and Health Services are individually accountable for their performance, and are required to report on their performance to the chief executive.

Services

19. For the purposes of the Act, a "*Service*" is a body corporate representing the State, with power to:

> *(a) enter into contracts and agreements; and*
>
> *(b) subject to subsection (2), acquire, hold, deal with or dispose of property; and*
>
> *(c) engage consultants or contractors; and*
>
> *(d) appoint agents and attorneys; and*
>
> *(e) charge for the services it provides; and*
>
> *(f) do anything else necessary or convenient to be done in performing its functions.*

20. The main function of a Service is "*to deliver the hospital services, other health services, teaching, research and other services stated in the service agreement for the service.*" Section 19(2) of the Act provides that a Service has additional functions including:

> *(e) to monitor and improve the quality of health services delivered by the Service, including, for example, by implementing national clinical standards for the Service; [and]*
>
> ...
>
> *(g) to undertaking minor capital works, and major capital works approved by the chief executive in the health service area.*

21. Each Service is controlled by a Hospital and Health Board, consisting of five or more members appointed by the Governor-in-Council on the recommendation of the Minister for Health.[7] At relevant times, the role of Chair of the West Moreton Hospital and Health Board was fulfilled by Timothy Eltham or Dr Mary Corbett.[8]

22. By s 32A of the Act, each Hospital and Health Board must establish an executive committee and appoint a "*health service chief executive*". At relevant times, the health service chief executive of West Moreton HHS was Dr Lesley Dwyer.

23. Provision for the establishment of Services is made in s 17:

> *A regulation may—*

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7 Act s 22, 23.

8 Eltham, pp 1 & 2.

> *(a) declare any 1 or more of the following to be a health service area for a Hospital and Health Service—*
>
> *(i) a part of the State;*
>
> *(ii) a public sector hospital;*
>
> *(iii) a public sector health service facility;*
>
> *(iv) a public sector health service; and*
>
> *(b) establish a Hospital and Health Service (**a Service**) for the health service area; and*
>
> *(c) assign a name to the Service.*

24. Schedule 1 to the Hospital and Health Boards Regulation 2012 (Qld) prescribes "West Moreton" to be a Hospital and Health Service (HHS) for a "Service area" that includes "The Park—Centre for Mental Health". The Barrett Adolescent Centre was located within that Service area. Accordingly, West Moreton HHS was responsible for the Barrett Adolescent Centre. [9]

The chief executive

25. Under the Act, "chief executive" is defined to mean "the chief executive of the department administering this Act".[10]

26. The functions of the chief executive are set out in s 45 of the Act as follows:

> *(a) to provide strategic leadership and direction for the delivery of public sector health services in the State;*
>
> *(b) to promote the effective and efficient use of available resources in the delivery of public sector health services in the State;*
>
> *(c) to develop Statewide health service plans, workforce plans and capital works plans;*
>
> *(d) to manage major capital works for proposed public sector health service facilities;*
>
> …

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9 Kingswell, [5].

10 The "chief executive" is different from a "health service chief executive" appointed by a Service.

(h) to deliver specialised health services;

(i) to arrange for the provision of health services to public patients in private health facilities;

(j) to develop and issue health service directives to apply to the Services;

(k) to enter into service agreements with the Services;

(l) to provide support services to Services;

(m) to monitor and promote improvements in the quality of health services delivered by Services;

(n) to monitor the performance of Services, and take remedial action when performance does not meet the expected standard;

(o) to receive and validate performance data and other data provided by Services;

(p) to provide performance data and other data to the Commonwealth, or an entity established under an Act of the Commonwealth;

(q) other functions given to the chief executive under this Act or another Act.

27. Section 44F of the Act provides that the chief executive is subject to the directions of the Minister for Health, but that in making decisions about particular individuals, he or she must act independently, impartially and fairly, and not subject to the direction of the Minister. It is apparent from s 44F of the Act that the chief executive is subject to the ultimate control of the Minister for Health, except with respect to decisions about particular individuals.

28. It is important to understand that the "chief executive" is different from the "chief health officer" for the State. The chief health officer is a public servant who provides high-level medical advice to the chief executive and the Minister for Health on health issues and policy matters.[11] At times relevant to these submissions, the chief health officer of Queensland was Dr Jeanette Young.

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[11] Act s 53(a) and (b).

29. Section 47 of the Act empowers the chief executive to "*develop and issue health service directives to Services for the following—*

> *(a) promoting service coordination and integration in the delivery of health services—*
>
> > *(i) between Services; and*
> >
> > *(ii) between Services, the department and other service providers;*
>
> *(b) optimising the effective and efficient use of available resources in the delivery of health services;*
>
> *(c) setting standards and policies for the safe and high quality delivery of health services;*
>
> *(d) ensuring consistent approaches to the delivery of health services, employment and the delivery of support services;*
>
> *(e) supporting the application of public sector policies, State and Commonwealth Acts, and agreements entered into by the State.*

30. Health service directives must be published in a way that allows the directive to be accessed by members of the public, and must be developed in consultation with the relevant HHS. [12]

31. A health service directive is binding on the Service to which it relates.[13]

32. The chief executive's power to issue health service directives reveals that the chief executive has an important supervisory function with respect to the provision of health services.

Service agreements

33. The expression "*Services agreement*" is defined in s 16(1) to mean "*an agreement between the chief executive and the Service that states—*

> *(a) the hospital services, other health services, teaching, research and other services to be provided by the Service; and*

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12 Act ss 48 and 49.

13 Act s 50.

(b) the funding to be provided to the Service for the provision of services, including the way in which the funding is to be provided; and

Example of a way of funding a health service—

activity-based funding

(c) the performance measures for the provision of services by the Service; and

(d) the performance data and other data to be provided by a Service to the chief executive, including how, and how often, the data is to be provided; and

(e) any other matter the chief executive considers relevant to the provision of services by the Service."

34. Execution of service agreements is dealt with in s 35 as follows:

(1) The chief executive and a Service must enter into a service agreement for the Service.

(2) The chair of the Service's board must sign the agreement on behalf of the Service.

(3) A service agreement is binding on the chief executive and the Service.

35. The Act provides that a service agreement must be for a term not longer than three years, must be negotiated by the chief executive and the HSS, and may include terms decided by the Minister in the event that the chief executive and HHS cannot agree on such terms.

36. The procedure by which a service agreement may be amended is set out in s 39 of the Act:

(1) If the chief executive or the Service wants to amend the terms of a service agreement, the party that wants to amend the agreement must give written notice of the proposed amendment to the other party.

(2) If the chief executive and the Service can not agree on the terms of the amendment, the party wanting the amendment must immediately advise the Minister—

(a) that they can not agree; and

(b) of the terms on which they can not agree.

(3) The Minister must decide the terms and advise the chief executive and the Service of the terms.

(4) For subsection (3), the Minister may decide that the amendment should not be made.

(5) The chief executive and the Service must include any terms decided by the Minister in the agreement.

37. Thus the relevant HHS must logically first decide that it wants an amendment. Where that involves closing a particular facility, the HHS would, it would follow, decide to cease operating the service and seek an appropriate amendment to the agreement. That in fact appears to be what happened in this case with the closure of the BAC.

38. Section 44 of the Act empowers the Minister for Health to give directions to a HHS:

(1) The Minister may give a Service a written direction about a matter relevant to the performance of its functions under this Act, if the Minister is satisfied it is necessary to do so in the public interest.

(2) Without limiting subsection (1), the Minister may direct a Service to give the Minister stated reports and information.

(3) However, the Minister may not give a direction about—

(a) the health services provided, or to be provided, to a particular person; or

(b) the employment of a particular person.

39. Dr Corbett's evidence was that the Minister for Health never provided a written direction under s 44 to the West Moreton HHS board in relation to the Barrett Adolescent Centre or the Redlands facility.

Summary of legislative scheme

40. The evident purpose of the Act is to establish a hierarchy of responsibility for the provision of public health services whereby principal responsibility for health services rests with the relevant HHS, and system-wide responsibility for the coordination of health services throughout the State rests with the Director-General

of the Health Department. It is to be noted that in delivering health services, HSS's are bound by the service agreement to which they are party, and must comply with any health service directive issued to the HSS by the chief executive; and must comply with any written direction issued by the Minister for Health pursuant to s 44.

Service agreements entered into by West Moreton HHS

41. Responsibility for the operation and management of the Barrett Adolescent Centre rested with the West Moreton HHS from 1 July 2012 until 29 August 2014.

2012-13 Agreement

42. On 28 June 2012, the chief executive, Dr Anthony O'Connell, executed the West Moreton 2012-13 Service Agreement (**2012-13 Agreement**) under s 317 of the Act. The 2012-13 Agreement commenced on 1 July 2012 and expired on 30 June 2013. From 1 July 2012, the Barrett Adolescent Centre was the responsibility of the West Moreton HHS. [14]

43. The 2012-13 Agreement contemplated that "*[i]n accordance with the* Hospital and Health Boards Act 2011 *the parties [ie, the chief executive and West Moreton HHS] will enter negotiations for the next service agreement at least six months before the expiry of the existing service agreement (ie, 31 December 2012).*"

44. Schedule 2 to the 2012-13 Agreement stated that the West Moreton HHS was responsible for operating "*The Park Centre for Mental Health*" facility, which included the Barrett Adolescent Centre.

13/16 Agreement

45. On 28 June 2013, the West Moreton HHS Service Agreement 2013/14 – 2015/16 (**13/16 Agreement**) was executed by Dr O'Connell and Dr Mary Corbett as Chair of the West Moreton HHS Board. The 13/16 Agreement is expressed to commence on 1 July 2013 and expire on 30 June 2016.

46. The objectives of the 13/16 Agreement are, relevantly, "*to specify the hospital services … to be provided by the HHS; [and] to specify the funding to be provided to the HHS for the provision of the services.*"

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[14] Kingswell, [7].

47. The 13/16 Agreement outlines[15] the relevant regulatory and legislative framework to be as follows:

> *The National Health Reform Agreement (NHRA) requires the State of Queensland to establish service agreements with each HHS for the purchasing of health services and to implement a performance and accountability framework including processes for remediation of poor performance. The* Hospital and Health Boards Act 2011 *states under section 35(3) that the service agreement executed between the Chief Executive and the Hospital and Health Board Chair binds each of them.*
>
> …
>
> *Under the* Hospital and Health Boards Act 2011 *one of the functions of HHSs is to comply with the health service directives that apply to the HHS. Section 50 of the* Hospital and Health Boards Act 2011 *states that a health service directive is binding on the HHS to which it relates. The HHS must also comply with other directions, such as directives applied under the* Public Service Regulation 2008.

48. Page 26 of the 13/16 Agreement states that the West Moreton "*HHS will provide a range of integrated mental health services and specialised alcohol and other drug services at … The Park Centre for Mental Health*".

49. Page 27 of the 13/16 Agreement states that, in respect of "*State-wide Services*", the West Moreton "*HSS has oversight responsibility for the delivery of the … Adolescent Extended Treatment and Rehabilitation Centre*", which is a reference to the Barrett Adolescent Centre. [16] The consequence of designating the Barrett Adolescent Centre as a "State-wide Service" means that the Barrett Adolescent Centre could accept patients from anywhere in Queensland. [17]

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15 13/16 Agreement page 5.

16 Evidence of Dr Corbett, T9-69.

17 Kingswell, [9].

Amendment to 13/16 Agreement

50. On 29 August 2014, a Deed of Amendment (**Amendment Deed**) with respect to the 13/16 Agreement was executed by Dr O'Connell and Dr Corbett as Chair of the West Moreton HHS Board.

51. Among other things, the Amendment Deed removed the "Adolescent Extended Treatment and Rehabilitation Centre" (ie, Barrett Adolescent Centre) from West Moreton HHS's responsibility for State-wide Services.[18]

DECISION TO CLOSE THE BARRETT ADOLESCENT CENTRE

52. An accurate understanding of the decision to close the Barrett Adolescent Centre (**Closure Decision**) requires an appreciation of:

    a. the events leading up to the Closure Decision; and

    b. the reasons motivating the Closure Decision.

53. This section sets out the significant events leading up to the Closure Decision. The following section (section 4), sets out and analyses the reasons motivating the Closure Decision.

54. The significant events precipitating the Closure Decision may be grouped into four stages:

    - **STAGE 1**: Preparation of the Queensland Plan for Mental Health 2007-17;
    - **STAGE 2**: Progression of the redevelopment of the Barrett Adolescent Centre;
    - **STAGE 3**: Cessation of the Redlands Project; and
    - **STAGE 4**: Closure Decision.

STAGE 1: Preparation of the Queensland Plan for Mental Health 2007-17

55. On 25 February 2008, the Queensland Cabinet approved the Queensland Plan for Mental Health 2007-2017 (**QPMH**). [19]

56. The QPMH provided "*a blueprint for reform of mental health care over the next ten years*" based on "*extensive consultations undertaken with mental health consumers,*

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[18] Evidence of Dr Corbett, T9-70.

[19] Cabinet Decision, Decision No 8012, Brisbane 25 February 2008, p 1 (DPC.003.001.0643).

carers, service providers and key stakeholders" with respect to each of its component parts. Dr Groves was one of the leaders of the group that developed the QPMH. [20]

Recommendation to redevelop the Barrett Adolescent Centre

57. To assist the preparation of the QPMH, Dr Groves established a number of groups to provide advice on specialised areas of mental health. One of those groups considered Child, Adolescent and Youth mental health needs. This particular group produced a report known as the Queensland Child and Youth Mental Health Plan 2006-2011 Report (**Child and Youth Report**). That report recommended that the Barrett Adolescent Centre should be "*redeveloped*".

58. It is important to appreciate that the Child and Youth Report did not recommend that the Barrett Adolescent Centre should be "*replaced*", "*replicated*", "*relocated*", "*reconstructed*" or "*rebuilt*". It was not contemplated that the Barrett Adolescent Centre would simply be transplanted to a newly-built facility off-site. The intention was rather to "*redevelop*" the Barrett Adolescent Centre. This redevelopment process naturally entailed a reassessment of the Barrett Adolescent Centre model of care, and an assessment of whether the services provided by the Barrett Adolescent should be provided elsewhere.

59. The Child and Youth Report stated that: [21]

> *The redeveloped Barrett Adolescent Centre will be staffed for 18 occupied in-patient beds (14 in an open module and 6 in a closed module) and 8 day patients.*
>
> *The closed module will incorporate 2 "swing" beds which can be used as a High Dependency Unit, with access to an enclosed outdoor space. This area will potentially provide extended care in a safe, more contained environment.*
>
> *The Centre will have the physical capacity to open a further 2 beds as needed. It is expected that these extra beds will be fully utilized and staffed as demand on the service increases.*
>
> *The redevelopment will require the rebuilding of the school and office buildings to accommodate the increased numbers of patients and staff.*

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[20] T7-76, line 39.

[21] Groves, Annexure AG-10

> *The redevelopment will include the capacity for a step-down, 2-bedroom independent living unit. on site, and the new model of care will incorporate accommodation for families and for adolescents attending the day program from a distance (through arrangements with a non-government provider).*

60. Thus, and 18 to 20 bed facility was contemplated. It is not clear whether the reference to the inclusion within the 6 bed "closed" unit of 2 "swing" beds for a "High Dependency Unit" is a reference to including an acute unit within the facility.

61. The Child and Youth Plan estimated that $17 million would be required for capital works associated with the redevelopment of the Barrett Adolescent Centre. That amount fed into the overall expenditure on mental health foreshadowed by the QPMH.

62. The QPMH foreshadowed expenditure of $121.55 million "to expand the range of acute and extended treatment beds by providing 140 new beds and to upgrade existing services to meet contemporary standards." [22]

63. The "Queensland Plan for Mental Health 2007-2017 Four Year Report", published in October 2011, noted that "*more than $148 million has been allocated towards 17 capital works projects, to deliver 277 new or upgraded inpatient beds for acute and extended stay treatment. This will result in a net increase of 146 new beds across Queensland.*" [23] The redevelopment of the Barrett Adolescent Centre was one of these 17 capital works projects.

Recommended delivery of Extended Forensic Treatment and Rehabilitation Unit at The Park

64. The QPMH also recommended a "services redesign" of The Park. In broad terms, this redesign process contemplated that The Park would provide services for adult forensic and secure patients only. The redesigned services would comprise a High Secure In-patient Service, an Extended Forensic Treatment and Rehabilitation Unit (**EFTRU**) (which was a new service), and a Secure Mental Health Rehabilitation for adults. All other clinical services at The Park campus would cease. [24]

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[22] QPMH page 18.

[23] Kingswell, [3]

[24] Kelly, [9.1(b)]

65. The EFTRU commenced operation on 29 July 2013 and patients were gradually transitioned into the unit.

STAGE 2: Progression of the redevelopment of the Barrett Adolescent Centre

Options for the redevelopment of the Barrett Adolescent Centre

66. Following the publication of the QPMH, the Mental Health Plan Implementation Team formed a subgroup (**site evaluation subgroup**) to evaluate options for the redevelopment of the Barrett Adolescent Centre. In October 2008, the site evaluation subgroup published a report titled "Report of the site evaluation subgroup: Site Options Paper for the redevelopment of the Barrett Adolescent Centre" (**Site Options Paper**).

67. The site evaluation subgroup considered the following sites as options for the redevelopment of the Barrett Adolescent Centre:

- Rogers Street Spring Hill;
- Child and Adolescent Forensic Treatment Unit – Royal Brisbane Hospital;
- Land adjacent to Redland Hospital;
- Meakin Park – 3 km from Logan Hospital Site (precise land parcel unknown-assume bushland between Queens Rd and Beal St); and
- The Park Centre for Mental Health (3 site options on campus considered).

68. The Site Options Paper found that "*Redland and The Park [were] the only architecturally viable options if the service is to be redeveloped as currently envisaged.*" Redevelopment at Redlands was considered to be the preferred option primarily because The Park was believed to be compromised by its close proximity to a forensic mental health service. As the Site Options Paper stated:

> *the close proximity of the [Park] site to the growing high security and extended treatment forensic programs compromise this option. Redeveloping the unit in close proximity to mentally ill offenders is likely to pose clinical and practical challenges and may become a matter of public interest.*[25]

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[25] Crompton, MSS.900.0002.0176.

69. The Site Options Paper noted that the Redlands "*site is marked as an Urban Koala Area [and] is adjacent to a large Koala Sustainability Area*" but "*[a]dvice from Project Services Environmental section [was] that development on this site should not be a problem.*" The Site Options Paper concluded that "*information currently at hand … indicates that this site would be suitable for the proposed Adolescent Unit.*"

70. On 4 November 2008, Professor David Crompton, received a memorandum from Dr Groves stating, [26] relevantly, that:

> *The replacement of the [Barrett Adolescent Centre] is one of 17 capital works projects associated with the Queensland Plan for Mental Health 2007-17, and is identified in the Outline of the 2007-08 State Budget Outcomes for Mental Health.*
>
> *An initial working group was formed comprising staff members involved in the existing [Barrett Adolescent Centre] and Project Services architects to consider the redevelopment of the unit and provide advice on the service model and design specification.*
>
> *…*
>
> *The "Site Evaluation Sub Group" was convened on the advice of the Area General Managers to provide advice on site options identified by Area Health Services.*
>
> *The consensus of the Site Evaluation Subgroup is that a vacant site adjacent to Redland Hospital constitutes the most appropriate option for the redevelopment of the unit.*

71. In March 2009, a report titled "Summary of Consultation on Site Selection" (**Consultation Report**) was published by Queensland Health. The Consultation Report stated that consultation focussed on:

- Consumer and Carer Perspectives
- Clinical Workforce
- Transport

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[26] Crompton, MSS.900.0002.0154-155.

- Risks associated with the surrounding environment
- Advantages and disadvantages of the local area
- Provision of school services by Education Queensland
- Impact of Clinical Services Capability Framework
- Collocation Options
- Time and cost implications of staged development and potential for future expansion

72. Consultation confirmed "*considerable support for the preferred option among members of the State-wide Child and Youth Subgroup, Child and Youth Design Reference Group and carers.*" [27]

Selection of the Redlands site

73. On the basis of recommendations made in the Site Options Paper, approval was sought from the Minister for Health to acquire the land known as Lot 30 Weippin Street, Cleveland (**Redlands Site**) for redevelopment of the Barrett Adolescent Centre. [28] Approval to purchase the Redlands Site was given on 15 January 2009 and the site was acquired by Queensland Health on 11 March 2009.

74. On 9 April 2009, Dr Groves provided Professor Crompton with the Consultation Report, together with a memorandum recommending that District Chief Executives endorse the proposal to redevelop the Barrett Adolescent Centre at the Redlands Site. That endorsement was given by the District Chief Executive of Metro South HHS.

75. A "user group" was subsequently established to progress the project.

Development of the model of service

76. The main task of the user group was to guide the design and redevelopment of the Barrett Adolescent Centre at the Redlands Site and "*to ensure that a facility would be developed that met the model of service (which was also to be developed).*" [29] The user group, which was comprised of a diverse range of people including those who

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27 Crompton, MSS.900.0002.0193.

28 Crompton, MSS.900.0002.0007 [29].

29 Crompton, MSS.900.0002.0008 at [34].

would be likely to work at the redeveloped unit once it was completed, held a number of meetings between 30 August 2009 and 15 March 2012.

77. The model of service to be delivered at the Redland Site was formulated by the user group over a series of meetings. At the inaugural meeting of the user group on 30 August 2009, Dr Sadler indicated that he would present a draft model of service at the next meeting. Dr Sadler did so at the second user group meeting on 17 September 2009. On 24 June 2010, being the 11th meeting of the user group, it was resolved that Professor Crompton should request that Child and Youth Mental Health Services should meet and finalise the draft model of service as a matter of urgency. This appears to have been done on or about 22 July 2010.

Key features of the Redlands model of service

78. The Redlands model of service sets out the key functions of the "*Adolescent Extended Treatment & Rehabilitation Centre*" as follows:

- *Ensure a level of admission consistent with least restrictive care and capacity to access the service. Level of admission will range from day admission to partial hospitalisation to providing 24-hour inpatient care for adolescents with high acuity in a safe, structured, highly supervised and supportive environment.*
- *Providing multidisciplinary and collaborative consultation, diagnostic assessment, treatment and evidence informed clinical interventions and rehabilitation including recovery and discharge planning for adolescents to facilitate reintegration back to community based treatment.*
- *Providing flexible, and targeted programs that can be delivered in a range of contexts including, school, community, group and family.*
- *Provide individually tailored, targeted, phased, evidence informed treatment interventions to alleviate or treat distressing symptoms and that will ultimately assist recovery and reintegration back into the community.*
- *Provide a range of interventions to assist progression in developmental tasks which may be arrested secondary to the mental illness.*

- *To provide family centred support and clinical interventions for families and carers to optimise adolescent functioning within their home environment.*
- *Provide intensive support to enable successful transition back to the community through arranging, coordinating and supporting access to a range of services for adolescents, to ensure seamless service provision. This will include the provision of step down accommodation for adolescents who cannot return home, who are in transition to the community and who remain in need of substantial clinical care while preparing for independent living in the community.*

79. What is significant for present purposes, is that the Redlands model of care preferred an "*institutionalised*" model of care, rather than a community-based model of care. The Redlands model of care contemplated that patients from all over Queensland would be treated at a single isolated facility, rather than in their local communities.

STAGE 3: Cessation of the Redlands Project

80. A decision to cease the Redlands Project was made by the Director-General of the Department of Health on 16 May 2012.

81. The principal reasons for the cessation of the Redlands Project are set out below.

Koalas

82. On 16 March 2011, the Department of Public Works (Project Services) (**DPW**) wrote to the Department of Environment and Resource Management (**DERM**) inviting DERM to comment on the proposed Ministerial designation for "community infrastructure" of the Redlands Site.

83. By letter dated 28 April 2011, DERM advised that it had reviewed the *Proposed Community Infrastructure Designation - Initial Assessment Report – Redland Bay Hospital* and provided a series of comments. Those comments include the following:

- That the Redlands Site was an "*SEQ threatened species habitat*", and provides "*core habitat for the koala* (Phascolarctos cinereus) *which is classified as vulnerable and a protected species under provisions of the* Nature Conservation Act 1992. *DERM recommended in this respect to consolidate "parking areas on Lot 29 … to minimise the footprint of the new development*

on Lot 30" and "*[i]f development of Lot 30 is unavoidable, the footprint should be minimised by restricting car parking to under buildings.*"

- That the Redlands Site was "*located within the Priority Koala Assessable Development Area where the [South East Queensland Koala Conservation State Planning Regulatory Provisions] applies.*" DERM advised DPW "to rethink the location and design of the facility to reduce the development footprint and retain a larger proportion of koala habitat on the site."

84. In other words, as at the end of April 2011, a little over 2½ years since the Site Options Paper, DERM was stating that there was a need to "*rethink*" both the "*location and design*" of the project. There is no basis for thinking that those processes had progressed appreciably by May 2012.

85. On 25 July 2011, the Deputy Director-General of the Health Planning and Infrastructure Division requested the preparation of a Briefing Note [30] for the approval of the Minister for Health regarding Town Planning Issues with respect to the Redlands Unit. This Briefing Note proposed that the Minister:

> ***Note*** *the Department is proceeding with option (a) … [t]hat is to delay seeking a Community Infrastructure Designation (CID) of Redland Hospital including Lot 30 Weippin Street, Cleveland until preliminary infrastructure planning has been completed for Redland Hospital.*
>
> ***Note*** *preliminary infrastructure planning of the Redland Hospital site is scheduled to be completed at the end of October 2011 and if required a master plan will be developed with completion in early 2012.*

86. This Briefing Note stated also that:

> *Advice from Department of Public Works, Project Services Environmental section is that development on this site should not be a problem. It is just a matter of applying a Koala Management Plan, which will cover such items as retention and planting of suitable trees and appropriate fencing. The type of development proposed should be compatible with these requirements.*

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30 QHD.004.014.8273

87. This expectation was not realised. The development of the Redlands Site was not problem-free. [31] The proximity of the Redlands Site to a koala habitat meant it was difficult to conclude a suitable design for the facility. As Dr Kingswell said:

> *[G]etting a building envelope within that site was ... complicated. And there were multiple iterations of the building design to try and fit a suitable building footprint. And each one that seemed to be produced ran into one problem or another.*

Fiscal Repair Strategy

88. On 24 March 2012, a Queensland State election was held which resulted in the election of a new government. The Government identified a substantial budget deficit, and projected that this deficit would increase significantly if corrective actions were not taken.

89. The Government established a Budget and Fiscal Examination Committee (**BFEC**), a Budget Review Committee (**BRC**), and commissioned an audit of Queensland's financial position (**Commission of Audit**). The BFEC functioned under the authority of the Director-General of Queensland Health, and provided advice and recommendations with respect to savings strategies for Queensland Health. The BFEC was "*a time limited Committee focused on immediate savings until 30 June 2012*". The BFEC appears to have met weekly from late May 2012. The BRC functioned under the authority of, and provided advice to, the Minister for Health via the Director-General. The first meeting of the BRC occurred on 28 May 2012, after which date the BRC met regularly until 2014. [32] The members of the BRC were, relevantly, the Minister for Health, the Hon Lawrence Springborg, the Director-General of Queensland Health, Dr O'Connell, and the Deputy Director-General of Queensland Health (Health Service and Clinical Innovation Division), Dr Michael Cleary.

90. Dr Kingswell recalls that in May 2012, he and Dr Cleary had a conversation in which Dr Cleary said "*we need to find $100 million of savings*". Dr Cleary gave evidence

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31 Nor was this process "painless". As Dr Kingswell said: "*This was a process that was years and years coming. And at May 2012, no design, no building approvals, the process for community infrastructure designation hadn't even commenced. Four years had gone past. I'm struggling to understand which bit of that was painless.*": T13-9

32 Cleary, page 5.

that he "*[did not] recall having that specific conversation with Dr Kingswell*" but said "*it could have been that I was in a meeting with Dr Young and she may have had that conversation with Dr Kingswell as her direct report.*" Dr Cleary added that "*I would have spoken with Dr Kingswell about [Hospital Health Funding] which is a separate pool of [federal] funding that was being considered at the time.*"

91. It is submitted that the totality of the evidence indicates that at around the time Government was establishing the BFEC and BRC in or before May 2012, Dr Kingswell was informed by either Dr Cleary or Dr Young that approximately $100-120 million worth of savings needed to be identified in the Queensland Health budget. Dr Cleary's uncontradicted evidence is that these savings needed to be identified "*in the first three months of the new State Government's appointment*". [33] There was a clear urgency in the task.

92. On 15 June 2012, the Commission of Audit published an interim report (**Interim Report**). The Interim Report identified spending patterns of different Government agencies, including Queensland Health, and raised concerns about budget management. The Interim Report projected that state debt would increase to approximately $100 billion by 2018-2019, and found that Queensland Health was a significant contributor to this debt. Moreover, it was found that Queensland Health's expenditure exceeded what was necessary to meet the general health needs of the State. The Interim Report advised that "*urgent fiscal repair is necessary*", and recommended a two-stage fiscal strategy, which came to be described as a "Fiscal Repair Strategy". The first stage involved taking measures to obtain "*a $3 billion improvement in the bottom line … over three years to 2014-15.*"

93. In effect, the Fiscal Repair Strategy required Queensland Health to look at expenditure that was discretionary, could be deferred, or was not effectively contributing to improved health outcomes. [34] As Dr O'Connell put it: [35]

> *The relevance of the Commission of Audit to the [Closure Decision] was that it influenced the overall fiscal environment in which Government agencies worked. Before the Commission of Audit, Queensland Health had an*

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33 Cleary, [32].

34 Cleary, [32].

35 DTO.900.0001.0008, at [10].

> *underlying deficit which had been worsening over the previous five years, reaching an overspend of approximately $291 million in the 2010-11 year.*
>
> *The Fiscal Repair Strategy influenced the budgetary environment in which Government agencies worked after the Commission of Audit, however, even if there had not been a Commission of Audit, the Redlands Unit would not have been progressed because … other reasons … warranted ceasing the project.*

Delays

May 2012 Briefing Note

94. The "*significant emphasis … on cost control within all areas of Queensland Health*" following the election of the Government in March 2012, [36] culminated in the preparation of a Briefing Note titled "*Cessation of the Redlands Adolescent Extended Treatment Unit Capital Program*" for the Approval of the Director-General. This Briefing Note (**May 2012 Briefing Note**) [37] was requested by the Chief Health Officer, Dr Jeannette Young, on 3 May 2012.

95. The May 2012 Briefing Note was prepared by Dr Leanne Geppert as Assistant Director of the Mental Health Alcohol and Other Drugs Branch (**MHAODB**) and cleared by Dr Kingswell as Executive Director of the MHAODB on 4 May 2012. The May 2012 Briefing Note was verified by Dr Jeannette Young on 12 May 2012.

96. Dr Jeannette Young's recollection is that she consulted a number of people in relation to the contents of the May Briefing Note, including Dr Groves, Dr Jagmohan Gilhotra and, to a lesser degree, Dr Kingswell (on the basis that he had occupied the position of Director Mental Health only for a short period of time at May 2012). [38] Dr Jeannette Young did not remember "*any change in advice*" when the person with whom she was consulting "*changed from Dr Groves to Dr Kingswell*". [39]

97. The May 2012 Briefing Note proposed that the Director-General should:

> ***Approve*** *the cessation of the Redlands Adolescent Extended Treatment Unit (RAETU) capital program [and]*

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36 Geppert, WMS.9000.0004.00004, [3.4].

37 DBK.001.001.0032.

38 T21-98

39 T21-98

Provide *this brief for the Minister for noting.*

98. The May 2012 Briefing note listed three "Headline Issues":

- *The RAETU capital program has encountered multiple delays to date and has an estimated budget over run of $1,461,224. Additionally, recent sector advice proposes a re-scoping of the clinical service model and governance structure for the Unit.*
- *There is an anticipated capital funding shortfall of 3.1 million for the regional mental health HHF projects, relating to Information Communications Technology (ICT), escalation and land acquisition. It is proposed to fund this shortfall through cost savings resulting from the cessation of the 15-bed RAETU which has been funded under Stage 1 of the* Queensland Plan for Mental Health 2007-17 *(QPMH).*
- *The HHF projects are critical in the reform of Queensland mental health services. The HHF projects focus on building community mental health service infrastructure in regional areas to facilitate a more integrated approach to service delivery in these areas – a key priority in the government's health reform agenda. This investment will address some of the inequities that exist for remote and rural consumers including lack of coordinated, integrated services that are close to their home.*

99. The May 2012 Briefing Note goes on to state that "*[c]easing the 15-bed RAETU capital program will necessitate a review of the existing adolescent centre at The Park, and should give consideration to the benefits and disadvantages of this model of care.*" The potential cost saving of not proceeding with the RAETU was calculated to be "*$15,150,524 in capital, and $1,824,979 in recurrent operating costs (from 2014-15).*"

100. The May 2012 Briefing Note records that the recommendation to cease the RAETU capital program "*was made after consultation with multiple stakeholders including the Health Planning and Infrastructure Division and Queensland Health, with some limited consultation also with the mental health sector and the Intergovernmental*

Funding and Policy Coordination Unit, Strategic Policy, Funding and Intergovernmental Relations Branch, Queensland Health." [40]

101. The May 2012 Briefing Note was approved by the Director-General on 16 May 2012 and was sent to the Minister for Health's office for approval. [41] It does not appear to have received approval, at least at that time.

102. Counsel Assisting are critical of the Director-General's approval of the May 2012 Briefing Note. It is suggested that he should have sought clarification as to the "*sector consultation*" to which the May 2012 Briefing Note refers. Counsel Assisting regard it as "*surprising*" that "*Dr Kingswell, Dr Geppert and Dr Young were confident enough to put such a proposition to Dr O'Connell is the absence of supporting information*" But Dr O'Connell did not find it "*surprising*". As he explained:

> *There has to be a level of trust throughout the [Department of Health]. It's a massive organisation. It's got 182 hospitals. At the time, it had 85,000 employees, and we're spending $12 billion a year. You know, it's larger than any of Australia's listed companies in terms of employees alone.*
>
> …
>
> *I would have received dozens of briefs every week in the role, and in the end, as you say, you have to trust the people who are advising you and providing the information.*

103. Furthermore, as the Briefing Note itself reveals, it was required to be done urgently.

104. By June 2012, the Budget Review Committee became aware that the Redlands Project "*had incurred multiple delays*".[42] By September 2012, there were no building approvals and the Redlands Project was more than 12 months behind schedule (the Redlands Project had, at one stage at least, an anticipated practical completion date of June 2012).[43]

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40 Kingswell, at DBK.900.001.0002.

41 O'Connell, [10(b)].

42 Cleary

43 Kingswell, at DBK.900.001.0002.

105. Dr O'Connell gave evidence that delays to the Redlands Project did not relate simply to the acquisition of the land, rather:

> *[T]here's a process that one goes through with the building of a new facility, new hospital buildings on an existing hospital site, which involves a number of steps, including purchasing the land, zoning it, getting infrastructure plans written. There's numerous steps which required before, eventually, the building goes up and it's commissioned. And there had been delays in a number of the[se] steps.*

106. There is in fact no evidence that the Redlands Project could ever have overcome the design and other technical problems that it had, or that even if it could have overcome them, it could have been completed within any time relevant to the closure of BAC.

107. It cannot be assumed that if the Redlands Project had not been ceased when it was, it could have been available as a service to which to transition BAC patients.

Budget over-runs

108. The May 2012 Briefing Note stated that the Redlands Project "*has an estimated budget over run of $1,461,224*", in circumstances where the project had been allocated approximately $16 million (the allocation changed over time[44]).

109. It is important to appreciate that the significance of the overrun amount cannot be gauged simply by comparing it with the $16 million which had been allocated to the Redlands Project. To consider the overrun amount as simply an 8% overrun is misleading in that it overlooks the manner in which capital projects were funded. As Dr Kingswell said in oral evidence:

> *what's important to understand in all of that is there was a finite budget, and it was a finite budget for the whole of the ... 17 capital projects. ... So you had to work within that cap, you had to deliver all of the 17 projects within that cap unless you wanted to go back to Treasury.*

110. Under examination by Counsel Assisting, Dr Kingswell continued:

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[44] T13-5

And do I take it from what you've just said that if you're the – if the project is 17th in time, that is, it's the last of the projects, then it ends up with whatever's left in the bucket?—That's potentially the outcome, yes.

…

Okay. Dr Kingswell, 1.4 million in a budget of 16, three or four years after the project was started doesn't seem a great escalation in a building project of this nature?—One point four out of 16 is not; that's right. But if it's actually seven [or] 10 out of a finite budget for the whole program, it is a significant budget overrun.

111. In addition, the overrun amount assumes particular significance when regard is paid to the restrained fiscal environment that existed at the relevant time. As Dr O'Connell said: [45]

the environment at the time was that the – the Newman Government had come into power and we had a commission of audit which had identified that there had been significant overspending by the Health Department for the budgets that had been allocated to it for the previous two years and that it was necessary to reduce both operational spending and capital spending to stay within the budget that was allowed and so that would have been the environment in which this – this was considered.

112. Further, it is important to consider the estimated budget in context, rather than in isolation. As Dr Geppert said:

I think what's important about this particular issue is it was a combination of factors. It wasn't just the budget overrun. The budget overrun is something that we were challenged with on and off throughout capital projects quite regularly. We – through meetings like that that you just were talking about [ie, the 18 June 2012 meeting of the Capital Works Working Group of which Dr Leanne Geppert was the Chair[46]], we very much monitored those sorts of things and tried to address as we went along and mitigate any risk to the capital project, but for this particular project, I would absolutely say that with

[45] Transcript Day 12 page 12 lines …

[46] See QHD.004.004.7733.

equal concern and barrier was the fact that there were environmental and capital issues associated with the site and location, and so they were – and they were considered to be unresolvable at the time. So that needs to be taken into the context as well as the budget overrun.

Uncontemporary model of care

113. Several witnesses gave evidence to the Commission that the Redlands model of care was uncontemporary. It is important to set out this evidence comprehensively.

Dr Anthony O'Connell

114. Dr O'Connell gave evidence that the most important factor in deciding not to proceed with the Redlands Project was that its model of care was uncontemporary. In his statement dated 6 January 2016, Dr O'Connell refers to "*an emerging clinical preference to care for patients currently treated in the [Barrett Adolescent Centre] in more community-based "closer-to-home" models of care, rather than in an institutionalised model.*" Dr O'Connell explained that this view was:

> *based on numerous conversations I have had over the last two decades with adult and child psychiatrists, executives within state health departments and health care planners, as well as documents authored by mental health specialists. One of these documents is the QPMH 2007-17 that states that the "Plan aims to develop a coordinated approach that provides a full range of services that: ... enable people who live with a mental illness to participate meaningfully in society." It goes on to say, "A stronger role is envisaged for the non-government sector as a key partner in delivering comprehensive community based care and support." It also has as one of its five Priorities for reform: "Priority 3: Participation in the community: Build capacity to assist and support people with mental illness to live full and meaningful lives in the community." As these are conversations going back many years I am not able to provide names of the parties involved or dates of the conversations.*
>
> *The beginnings of these emerging preferences probably first appeared in a public conversation after the release of the Richmond Report in 1983 written for the NSW Department of Health. In Oct 2014 the NSW Mental Health Commission' said that it was republishing the report on-line because the Report "is a valuable and much cited resource". It went on to say "The*

> *Richmond Report was about redressing the imbalance between institutionalized hospital care and community care in mental health services while advocating strongly for a more decentralized and integrated model of care and support." David Richmond AO, author of the report has said, "Under the report, some institutions were targeted for closure, but not before both growth and compensatory community services were provided. As institutions were closed the funding which previously supported institutional care would transfer to community care and support." It was always my intention that a similar process of shifting focus and resourcing would occur while I was Director-General in Queensland, and the statement by WMHHS that I have quoted in paragraph 16{d} "Board approved the closure of BAG dependent on alternative appropriate care provisions for the adolescent target group" reassured me that WMHHS shared my opinion. I have not suggested that there is never a need for certain mental health patients to be hospitalized (acutely or in extended bed-based care), nor have I acted in a way that would suggest that. The BAC did not close while I was Director-General.*

Dr Jeannette Young

115. Dr Young, the Chief Health Officer of Queensland at times relevant to these submissions, gave evidence that the statement in the May 2012 Briefing Note that "*recent sector advice proposes a re-scoping of the clinical service model and governance structure for the Unit*" was based on consistent advice she received from Dr Groves, Dr Gilhotra and, to a lesser degree, Dr Kingswell. In this regard, Dr Young said:

> *Prior to seeking the Director-General's approval, and prior to preparation of the briefing note, I would have consulted over an extended period with the Executive Director of Mental Health, who is an expert psychiatrist and, at the time, was also the statutory appointee to the role of Chief Psychiatrist. I am certain the Executive Director would have also sought advice from child or adolescent psychiatrists.*
>
> *I cannot recall the detail of any such advice, nor do I have control of any documents containing the advice. I believe the information would have been conveyed to me as part of my regular meetings with the Executive Director.*

> *The only thing I can recall about the advice was that the model of care proposed at Redlands (being a single facility to serve the entire State) was out dated.*
>
> *Before a briefing note such as the one in question is prepared, there are many discussions about the issue over many months, as the ideas the subject of the briefing note are tested and refined.*

116. Dr Young also said that she "*considered the merits of the proposal to cease the [Redlands Project] in the months leading up to the [May 2012 Briefing Note], as part of the regular meeting [she] had with the Executive Director [ie, Dr Kingswell] and the Director-General [Dr O'Connell]. I did so through discussion and debate around the issue.*"

117. Clearly enough, Dr Young formed her own view as to the merits of ceasing the Redlands Project. The fact that she requested and verified the May 2012 Briefing Note indicates that she supported the view that the "*clinical service model*" for the Redlands facility required "*re-scoping*".

Dr Geppert

118. Dr Geppert authored the May 2012 Briefing Note which recommended the cessation of the Redlands Project for reasons associated with its model of care. It is a natural inference that she agreed with that recommendation for those reasons. Her evidence as to the meaning of the statement "*recent sector advice proposes a re-scoping of the clinical service model and governance structure for the Unit*" was as follows:

> *So in May 2012, the context of what was occurring within the sector at that period of time was very much an overall reform of the mental health service sector. Clearly, the Queensland Plan for Mental Health was the primary vehicle for that, and my particular unit within the branch had a great deal to do with that process of reform. And – so there were many models of service that were actually being re-scoped and reconsidered, to the point where I believe if you go back to Queensland Plan Mental Health documents that was one of the highlighted actions that were occurred through the plan. There was a state-wide project that was commenced and implemented, which at one stage I had direct involvement with as a project manager prior to my time as director, and that particular project was to develop consistent service models*

> *across the state at all levels of clinical care, so across the age continuum of services provided. And as part of that process, there would be – absolutely be a reform agenda around that, so identifying ways to not only make care across Queensland consistent within the same service type, but also looking at opportunities for improvement, opportunities to, I guess, develop more contemporary service models against national and state agendas, those sorts of things.*

119. Dr Geppert added with respect to the Redlands model of service that:

> *The intention was to review, and where opportunity arose, absolutely revise and improve upon so that, in fact, it was intended to be a new model of service. There was no intention to actually pick Barrett up as a centre as it currently stood and move it to another site. I believe it's a demonstration of good practice, clinical and project planning alike, that if you have an opportunity like that you would absolutely consider are there any gaps, are there opportunities for improvement and how can we do this better.*

120. The effect of Dr Geppert's evidence is that the Redlands Project provided an opportunity to assess and revise the model of care employed at the Barrett Adolescent Centre. Her opinion was that the model of care employed at the Barrett Adolescent Centre merited revision in order to align it with contemporary service models outlined in the QPMH.[47]

Dr Kingswell

121. Dr Kingswell cleared the May 2012 Briefing Note and agreed with its contents. The basis for his agreement was:

> *consultation with multiple stakeholders including the Heath Planning and Infrastructure Division and Queensland Health, with some limited consultation also with the mental health sector and the Intergovernmental Funding and Policy Coordination Unit, Strategic Policy, Funding and Intergovernmental Relations Branch, Queensland Health.*

122. Dr Kingswell's evidence was that the Redlands model of care, to the extent that it replicated the "institutionalised" model of care employed at the Barrett Adolescent

[47] Transcript Day 10 pages 7-9.

Centre, was uncontemporary and inconsistent with the National Mental Health Service Planning Framework. It is important to understand in this regard that even though the Redlands model of care may have been consistent with the QPMH, the significance of the QPMH had diminished by 2012. As Dr Kingswell said:

> *[T]here's a whole lot of reasons why the [QPMH] had become completely irrelevant by early 2012. So in August 2011 the state reached the National Health Reform Agreement with the Commonwealth that committed the state to delivering statutory entities referred to in Queensland as HHSs and changed the funding arrangements between the funding arrangements between the state and the Commonwealth fundamentally. And made – and it rendered that plan completely obsolete in that if you read that plan it's an input based model. It talks about beds and staff and so on. But you can't write an agreement with the Hospital and Health Service around that. You have to write an agreement with the Hospital and Health Service in terms of these are the services that we expect you to deliver, this is the unit price we're prepared to pay for those services and these are the outcomes that we expect you to achieve. This plan was obsolete for that reason. It was also made in part obsolete by the National Mental Health Service's Planning Framework. So the fourth National Mental Health Plan which was committed to by all Australian governments had under its remit one action which was to deliver a nationally consistent set of service elements. That work went on between 2011 and 2013. It cost the Commonwealth something like $2 million and it involved extensive consultation with all jurisdictions. There were consumer and carers and advocacy groups and clinicians and so on involved in that consultation. And I think the Commission has those documents and can see the taxonomy and the service element description that that plan envisages. And within that, there are extended treatment beds for adolescents and they're referred to as Step Up Step Down units and the model that is anticipated is the YPARC model, the Youth Prevention and Recovery Centres that are found in Victoria. Now, that planning group [ie, the National Mental Health Plan Planning Group] had available to them other potential models such as the Walker and Rivendell Unit in New South Wales and the Barrett Centre in Queensland. They did not come back and say that they thought that the Barrett Adolescent Centre or the*

Redlands Unit that would have replaced it was a service element that they wanted to see in Australia.

123. It is worth noting that Dr Kingswell's opinion as to the Redlands model of care being out-dated was evidently accepted by Dr Cleary. As Dr Cleary said in his statement dated 21 December 2015:

> *Dr Kingswell recommended consideration of alternative models moving from institutional to community based care. Dr Kingswell also indicated that continuation of the Redlands project was not appropriate for a range of reasons including:*
>
> - *the proposed unit continued a model of care that was now not considered contemporary. Contemporary models were moving from institutional care to community based care. Dr Kingswell indicated that there was work being undertaken nationally that Indicated that Institutional models of care were not considered contemporary under the draft "National Mental Health Service Planning Framework".*

124. Dr Kingswell's view matched Dr Cleary's own view that the Redlands model of care was uncontemporary. In this regard, it is important to bear in mind that Dr Cleary said under examination by Counsel Assisting that:

> *The – the advice that I received was consistent with the National Mental Health planning frameworks that were in place and the National Mental Health plans that had been in place for quite some time. Those plans had really outlined the move that has occurred over the last decade and a half away from institutional care to community-based care and identify many of the benefits that flow from that change. I – I received those documents through many forums, including my representing Queensland on the Australian Health Ministers Advisory Council, where the mental health subgroup reported and provided their planning framework, and I think at that stage the second mental health – sorry, my apologies – the third mental health plan was being presented and being revised by the various state institutions or state governments, and was then progressed to ministers. It outlined, really, quite a strong case for a move from institutional to community-based care. In addition to that, there were documents that I think Dr Kingswell was aware of*

that had been developed locally in terms of Queensland-based documents that related more directly to the Barrett Adolescent Centre or adolescent services that were provided on the campus at Ipswich.[48]

125. Dr Kingswell views were entirely consistent with other expert views and were perfectly reasonable and soundly based. His opinion that the Redlands model of care was not contemporary aligns with the views of other witnesses, including Dr O'Connell, Dr Young and Dr Geppert and Dr Cleary. The notion that these expert clinicians based their view of the Redlands model of care solely on advice they received from Dr Kingswell is not supported by the evidence. To the contrary, each of these witnesses relied on an array of advice from various sources. Any suggestion that these others slavishly followed the advice of Dr Kingswell ignores the fact that each witness was eminently qualified to—and did—form their own independent views.

126. Furthermore, there is no expert evidence that an 18 to 20 bed centralised and stand-alone inpatient facility, such as was planned for Redlands, was reflective of contemporary thinking at that time.

August 2012 Briefing Note

127. On 10 August 2012, Vaun Peate, the Senior Department Liaison Officer between the Minister for Health's Office and the Department of Health, requested the preparation of two separate briefing notes: one for the approval of the Director-General of the Department, the other for the approval of the Minister. It is convenient to refer to the ministerial Briefing Note as the "August 2012 Briefing Note" and the briefing note to the Director-General as the "D-G Briefing Note". The subject of both briefing notes was "12 Rural Infrastructure Projects".

128. The D-G Briefing Note lists the following "Headline Issues":

- *2010 planning at 12 rural hospitals identified infrastructure Issues.*
- *Funding strategy identified within existing capital program with minimum expenditure for targeted prioritised infrastructure rectification to improve safety and functionality In the short-term.*

[48] Transcript Day 14 page 9 lines

- *Detailed planning will follow for medium and longer term solutions.*
- *Funding strategy cessation and/or deferral of projects for relates to replacement/collocation of existing services and not service expansion.*

129. The D-G Briefing Note also provides the following "Background" information:

- *Service profiles and Infrastructure plans were prepared for the 12 sites (Atherton, Ayr, Biloela, Charleville, Charters Towers, Emerald, Kingaroy, Longreach, Mareeba, Roma, Thursday Island, Sarina) which informed the development of the Preliminary Evaluation, with . all completed In 2010 (Attachment 4 BR054344 Service and Infrastructure Planning for Rural and Remote Areas).*
- *The current identified capital savings totalling $63.2 million as outlined in the July 2012 Cabinet Budget Review Submission is documented in Attachment 5.*
- *In addition to the $63.2 million capital savings, further potential capital savings have been identified totalling $41 million (Attachment 6).*
- *These $14 [sic: 41] million sayings for 2012-2012 relate to cessation of projects for replacement/collocation of existing services and not service expansion.*

130. It is uncontroversial that the cessation of the Redlands Project contributed to the "*further potential capital savings ... totalling $41 million*" referred to in dot-point three above.

131. The D-G Briefing Note was "noted" by the Director-General (the document was signed by Dr Young) on 17 August 2012.

132. The August 2012 Briefing Note to the Minister invites the Minister to do the following:

> ***Approve*** *the planned strategy for the targeted rectification of the prioritised Infrastructure issues and subsequent planning for 12 rural hospitals.*
>
> ***Note*** *the recommended $41 million funding strategy for 2012-2013 for the rural infrastructure rectifications from the Capital Program, of:*

- *Cessation of the Sunshine Coast Health Precinct and Caboolture Health Precinct projects;*
- *Cessation of the Replacement Adolescent Extended Treatment Unit, Redlands Project;*
- *Deferral of the Townsville Medium Secure Rehabilitation Unit refurbishment project until 2013-2014*

***Note** that a further $10.58 million is being allocated from "Closing the Gap" funding.*

***Note** consultation will occur following approval of the recommended funding strategy.*

***Note** that the 2010 planning at 12 rural hospitals identified infrastructure issues.*

***Note** that the funding strategy identified within existing capital program with. Minimum expenditure for targeted prioritised infrastructure, rectification to improve safety and functionality in the short term.*

***Note** that detailed planning will follow for medium and longer term solutions.*

***Note** that the funding strategy relates to cessation and/or deferral of projects for realignment/collocation of existing services and not service expansion.*

133. The August 2012 Briefing Note was noted by the Minister's Chief of Staff on 27 August 2012, and was approved by the Minister on 28 August 2012. This effectively terminated the Redlands Project and re-allocated the capital funding to the 12 rural hospital projects.

August 2012 Memorandum

134. On 28 August 2012, Glenn Rashleigh, Chief Health Infrastructure Office, System Support Services, delivered a memorandum, the subject of which was "Cancellation of Capital Delivery Project", to Lesley Dwyer as Chief Executive of West Moreton HHS and Dr Richard Ashby as Chief Executive of Metro South HHS (**August 2012 Memorandum**)

135. The August 2012 Memorandum advised as follows:

> *The purpose of this memo is to advise of a decision by government to cancel or defer a small number of capital delivery projects.*
>
> *This includes the cancellation of the replacement Adolescent Mental Health Unit at Redlands from the current location at Wacol.*

136. The memorandum effectively confirmed that the Redlands Project had been cancelled.

STAGE 3 (2013): Closure Decision

137. There is conflicting evidence as to when the Closure Decision was made, and by whom.

138. Timothy Eltham and Dr Mary Corbett gave evidence that Closure Decision was made by the Queensland government at some time prior to the enactment of the *Hospital and Health Boards Act* in 2011.

139. The Minister for Heath, the Hon Lawrence Springborg, gave evidence that the Closure Decision was made by the West Moreton HHS in 2013.

140. Dr Kingswell's evidence was that the Closure Decision was made by the Minister for Health in consultation with the Director-General and the West Moreton HHS.

141. Having regard to the totality of the evidence, it is submitted that the Closure Decision crystallised on 15 July 2013, once the Minister for Health had given his support to the "*decision*" of the West Moreton HHS on 23 May 2013 "*to support the proposed closure of BAC*".

142. The sequence of principal events leading up to the closure decision are as follows.

23 November 2012 meeting of West Moreton HHS Board

143. On 23 November 2012, the West Moreton HHS Board met. The minutes of that meeting refer to the "potential closure of the Barrett Adolescent Centre". In particular, the minutes record [49] that:

> *In accordance with the Statewide Mental Health Plan, The Park - Centre for Mental Health is to become an adult forensic centre, anticipating July 2013. It*

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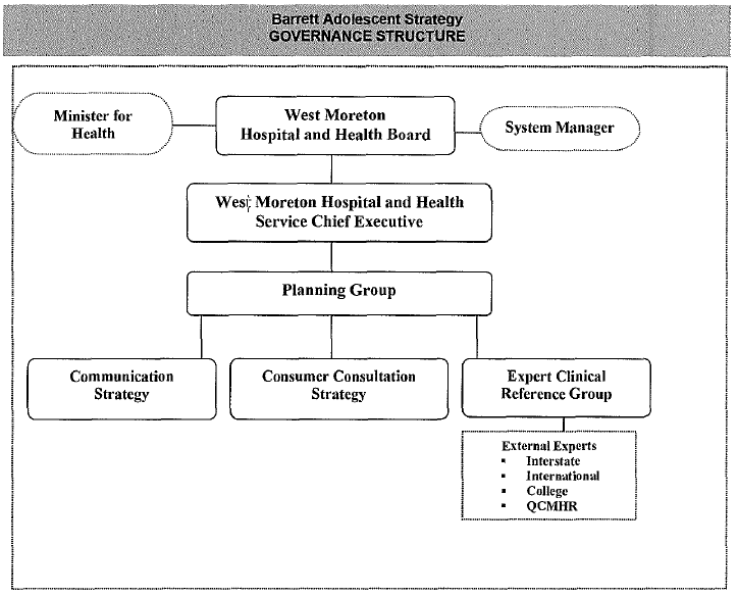
[49] Eltham, at WMB.9000.0002.00087-00088.

will no longer be appropriate to have young teenagers on a campus for adults in a medium to high security setting.

…

- *Staff have been briefed on potential issues and advised that no formal decision has been made by the WMHHS Board.*
- *A meeting was held on Thursday, 15 November 2012 with key Child and Youth Psychiatrists, WMHHS Chief Executive and Executive Director Mental Health and Specialised Service and System Manager with agreement reached that a Planning Group be formed to lead the planning, consultation and development of options and final recommendation for decision. This Planning Group will be supported by a clear communication strategy, a consumer consultation strategy and an expert clinical reference group with appointed membership from representative groups as well as interstate and national experts.*
- *An action plan will be developed with the Planning Group by Wednesday, 21 November 2012 and provided to the Board for endorsement.*

144. The relationship between the Planning Group and Expert Clinical Reference Group (**ECRG**) was described in a "Project Plan" developed by Chris Thorbun. This Project Plan was presented at the referred to in the second dot-point quoted above. The Project Plan represented (diagrammatically) the governance structure of the Planning Group and ECRG as follows:



The Planning Group

145. The members of the Planning Group were:

- Ms Sharon Kelly (Chair)
- Mr Chris Thorburn, then Director of Strategy Mental Health and Specialised Services;
- Dr Kingswell;
- Dr Geppert;
- Dr David Hartmann, Clinical Director, Community Youth Mental Health Service (**CYMHS**), Townsville Hospital and Health Service;
- Dr Sadler;
- Dr Stephen Stathis;
- Ms Michelle Bond, Principal, Royal Children's Hospital School;
- Naomi Ford, Rowdy Communications (in relation to communication strategy).

146. The Planning Group was to report to WMHHS Chief Executive, Ms Dwyer.

Establishment of the Expert Clinical Reference Group (ECRG)

147. On or about 23 November 2012, Dr Geppert was appointed to chair the ECRG. Together with Dr Leanne Geppert, the members of the ECRG were:

- Dr Sadler;

- Dr Michele Fryer, Faculty of Child and Adolescent Psychiatry;
- Dr James Scott, Consultant Psychiatrist Early Psychosis, Metro North Hospital and Health Service;
- Dr David Hartman, Clinical Director, Community Youth Mental Health Service, Townsville Hospital and Health Service;
- Professor Philip Hazell, Director, Infant Child and Adolescent Mental Health Services, Sydney and South-Western Sydney Local Health Districts;
- Ms Josie Sorban, Director of Psychology, Community Youth Mental Health Service, CHQHHS;
- Ms Amanda Tilse, Operational Manager, Alcohol, Other Drugs and Campus Mental Health Services, Mater Children's Hospital;
- Ms Amelia Callaghan, State Manager Queensland, NT and WA, Headspace;
- Ms Emma Hart, Nurse Unit Manager, Adolescent Inpatient Unit and Day Service, Townsville Hospital and Health Service;
- Mr Kevin Rodgers, Principal of the Barrett School;
- a consumer representative; and
- a carer representative.

148. The Terms of Reference of the ECRG (which appear to have been finalised by the Planning Group on 30 November 2012) explained the purpose, and scope and functions of the ECRG as follows:

> ***1. Purpose:***
>
> *1.1 The purpose of the Expert Clinical Reference Group is to:*
>
> *Provide expert clinical advice to promote the development of a contemporary evidence based model of care to meet the needs of adolescent mental health consumers who experience severe and persistent psychiatric symptomatology that significantly interferes with social, emotional, behavioural and psychological functioning and development.*
>
> ***2. Scope and Functions***

2.1 The Expert Clinical Reference Group will consider that the model(s) of care:

- *will clearly articulate a contemporary model(s) of care for subacute mental health treatment and rehabilitation for adolescents in Queensland*
- *will be evidenced based, sustainable and align with Queensland mental health policy, current statewide models of service, National mental health policy, National mental health service planning frameworks and future funding models.*
- *will take into account the Clinical Services Capability Framework (for Mental Health) and*
- *will replace the existing Statewide services provided by Barrett Adolescent Centre – The Park.*

149. Dr Kingswell expressed his frustration that the ECRG had not used terminology that accorded with the taxonomy of the National Mental Health Planning Framework. That is explicable given that it was expressly included in the terms of reference for the ECRG that the models of care would "*align with* [inter alia] *National mental health service planning frameworks".*

ECRG Report

150. The ECRG finalised its report (ECRG Report) on 8 May 2013.

151. The ECRG Report states that it is an "*elements document[,]* ***not a model of service*** *– it is a conceptual document that delineates the key components of a service continuum type for the identified target group.*" (emphasis in original)

152. The ECRG Report proposed:

"four tiers of service provision for adolescents requiring extended mental health treatment and rehabilitation:

- ***Tier 1*** *– Public Community Child and Youth Mental Health Services (existing);*
- ***Tier 2a*** *– Adolescent Day Program Services (existing + new);*
- ***Tier 2b*** *– Adolescent Community Residential Service/s (new); and*

- ***Tier 3*** *– Statewide Adolescent Inpatient Extended Treatment and Rehabilitation Service (new)."*

153. With respect to Tier 3, the ECRG Report states:

> *The final service model elements document produced was cognisant of constraints associated with funding and other resources (e.g. there is no capital funding available to build BAC on another site). The ECRG was also mindful of the current policy context and direction for mental health services as informed by the National Mental Health Policy (2008) which articulates that 'non acute bed-based services should be community based wherever possible'. A key principle for child and youth mental health services, which is supported by all members of the ECRG, is that young people are treated in the least restrictive environment possible, and one which recognises the need for safety and cultural sensitivity, with the minimum possible disruption to family, educational, social and community networks.*
>
> …
>
> *[I]t is the view of the ECRG that like the Community Care Units within the adult mental health service stream, a design-specific and clinically staffed bed-based service is essential for adolescents who require medium-term extended care and rehabilitation. This type of care and rehabilitation program is considered life-saving for young people, and is available currently in both Queensland and New South Wales (e.g., The Walker Unit).*

154. The second and third recommendations of the ECRG Report are particularly relevant to the Closure Decision; and it is desirable to set them out in full:

> ***2. Inpatient extended treatment and rehabilitation care (Tier 3) is an essential service component***
>
> - *It is understood that the combination of day program care, residential community-based care and acute inpatient care has been identified as a potential alternative to the current BAC or the proposed Tier 3 in the following service model elements document.*
> - *From the perspective of the ECRG, Tier 3 is an essential component of the overall concept, as there is a small group of young people whose*

needs cannot be safely and effectively met through alternative service types (as represented by Tiers 1 and 2).

- *The target group is characterised by severity and persistence of illness, very limited or absent community supports and engagement, and significant risk to self and/or others. Managing these young people in acute inpatient units does not meet their clinical, therapeutic or rehabilitation needs.*
- *The risk of institutionalisation is considered greater if the young person receives medium-term care in an acute unit (versus a design-specific extended care unit).*
- *Clinical experience shows that prolonged admissions of such young people to acute units can have an adverse impact on other young people admitted for acute treatment.*
- *Managing this target group predominantly in the community is associated with complexities of risk to self and others, and also the risk of disengaging from therapeutic services.*

Recommendation:

a) A Tier 3 service should be prioritised to provide extended treatment and rehabilitation for adolescents with severe and persistent mental illness.

3. Interim service provision if BAC closes and Tier 3 is not available is associated with risk

- *Interim arrangements (after BAC closes and before Tier 3 is established) are at risk of offering sub optimal clinical care for the target group, and attention should be given to the therapeutic principles of safety and treatment matching, as well as efficient use of resources (e.g., inpatient beds).*
- *In the case of BAC being closed, and particularly if Tier 3 is not immediately available, a high priority and concern for the ECRG was the 'transitioning' of current BAC consumers, and those on the waiting list.*

- *Of concern to the ECRG is also the dissipation and loss of specialist staff skills and expertise in the area of adolescent extended care in Queensland if BAC closes and a Tier 3 is not established in a timely manner. This includes both clinical staff and education staff.*

Recommendations:

a) *Safe, high quality service provision for adolescents requiring extended treatment and rehabilitation requires a Tier 3 service alternative to be available in a timely manner if BAC is closed.*

b) *Interim service provision for current and 'wait list' consumers of BAC while Tier 3 service options are established must prioritise the needs of each of these individuals and their families/carers. 'Wrap-around care' for each individual will be essential.*

c) *BAC staff (clinical and educational) must receive individual care and case management if BAC closes, and their specialist skill and knowledge must be recognised and maintained.*

155. The significance of these recommendations as far as the Closure Decision is concerned is analysed in section 4 below.

Consideration of the ECRG Report by the Planning Group

156. The Planning Group considered the ECRG Report and prepared its own report (**Planning Group Report**) setting out the Planning Group's response to each recommendation made by the ECRG.

157. Recommendations 2 and 3 of the ECRG Report were accepted by the Planning Group.

The Planning Group's response to Recommendation 2(a) of the ECRG Report was:

Accept with the following considerations.

Further work is needed to detail the service model for a Tier 3. Models involving a statewide, clinical bed-based service (such as the Barrett Adolescent Centre) are not considered contemporary within the National Mental Health Service Planning Framework (in draft). However, there are alternative bed-based models involving clinical and non-clinical service

components (e.g., Y-PARC in Victoria) that can be developed in Queensland to meet the requirement of this recommendation.

Contestability reforms in Queensland may allow for this service component to be provider agnostic.

158. The reference to "further work" being required is, of course, precisely what the ECRG had itself noted in Recommendation 1 would be required.

159. The reference by the Planning Group to the fact that models "*involving statewide, clinical bed-based service (such as the Barrett Adolescent Centre) are not considered contemporary within the National Mental Health Service Planning Framework"* is not contrary to anything said by the ECRG. The Planning Group accepted that the service elements for what the ECRG included in its Tier 3 categorisation would be provided. The ECRG had expressly said that it was not setting out "*how the key components* [would] *function at a service delivery level*" nor anything about how they would be funded or implemented.

160. Whilst some of the discussion of what the ECRG had recommended may sometimes have been construed as if it recommended a centralised stand-alone facility, or a new purpose-built facility, the ECRG report does not in fact do so.

161. Counsel Assisting have submitted that "*The Planning Group noted that this (presumably closure) was feasible to commence now. Only Dr Kingswell seems to have said this.*" That is a mis-construction of the documents. Plainly, the reference in notes of a Planning Group meeting to Dr Kingswell saying that something could "*commence now*" a reference to the planning process for the individualised care of the existing BAC consumers. That is reflected in the words of the Planning Group report at item 3(b) where it states, in relation to the recommendation of the ECRG about interim arrangements and wrap-around care:

> "*While this may be a complex process for some consumers and their individual needs, it was noted that this course of action could start immediately, and that it was feasible.. The potential to utilise current BAC operational funds (temporarily) to 'wrap-around' each consumer's return to their local community was noted as a significant benefit*."

24 May 2013 Meeting of West Moreton HHS

162. On 24 May 2013, the West Moreton HHS Board met and considered the ECRG Report and Planning Group Report.

163. With respect to the Barrett Adolescent Centre, the Board meeting minutes state the following:

> *Sharon Kelly, Executive Director Mental Health and Specialised Services, joined the meeting. The Board discussed the recommendation from the Planning Group that proposes the closure of the Barrett Adolescent Centre and the issues that this presents. The Board recognised that the Barrett facility is no longer suitable but is concerned that there is currently no alternative for consumers. The Board noted the recommendations of the Barrett Adolescent Strategy Planning Group, and the need to move as rapidly as possible to an alternative model based on those recommendations.*
>
> *…*
>
> ***DECISION:*** *The Board approved the development of a communication and implementation plan, inclusive of finance strategy, to support the proposed closure of BAC.*

164. It is convenient to refer to this "decision" as the "24 May 2013 Resolution of the WMHHS Board".

165. Timothy Eltham and Dr Corbett each gave evidence that the 24 May 2013 Resolution of the WMHHS Board did not amount to a decision that the Barrett Adolescent Centre should be closed. In this regard, Timothy Eltham said:

> *The [West Moreton HHS Board] supported the decision to close subject to the development of a new model of service for patients. The [West Moreton HHS Board] did not (and had no power to) make a decision to close BAC and noted in the Minutes of its meeting on 26 July 2013 that references in agenda papers for that meeting referring to closure 'must be read as referring to the proposed closure of BAC in light of the fact that no firm decision to close the facility has been made until alternative options for providing improved models of care have been identified'.*

166. Similarly, Dr Mary Corbett said:

> *The [West Moreton HHS Board] didn't have power to close the Barrett Centre.*
>
> *...*
>
> *The [West Moreton HHS Board] ... had a number of functions within [the] framework [set up by the Act]. One of those functions would not have been to close a health system service.*

167. It is arguable whether the West Moreton HHS Service lacked power to close the Barrett Adolescent Centre.

168. The Act empowers an HHS to "*do anything else necessary or convenient to be done in performing its functions*". The 2012-13 Agreement (in force at the time) obliged West Moreton HHS to operate and manage the Barrett Adolescent Centre as part of its responsibility to provide a health service at The Park Centre for Mental Health. That was a contractual obligation rather than a limit upon a statutory power.

169. West Moreton HHS had power to decide the manner in which its health services were to be delivered and indeed to close a particular unit. [50] Whether that would have meant that WMHHS was in breach of the agreement is another matter.

170. It is, in any event unnecessary for the Commission to decide, as a matter of law, whether West Moreton HHS's purported decision to close the Barrett Adolescent Centre had legal effect, because of what followed the 24 May 2013 Resolution of the WMHHS Board.

17 June 2013 Meeting

171. On 17 June 2013 the Director-General, Dr O'Connell, Deputy Director-General, Dr Cleary, along with Lesley Dwyer, Sharon Kelly and Dr Geppert met to discuss the 24 May 2013 Resolution of the WMHHS Board (**17 June 2013 Meeting**). Lesley Dwyer's uncontradicted evidence is that the Director-General and Deputy Director-General gave in principle support for the closure of the Barrett Adolescent Centre and development of a new model of service. In addition, the Agenda Paper written by Sharon Kelly for the 28 June 2013 meeting of the West Moreton HHS Board notes that:

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[50] *Acts Interpretation Act* 1954, ss 23, 24AA

A meeting was held Monday June 17th with the Director General (Dr O'Connell), DDG Health Services and Clinical Innovation (Dr Cleary), Lesley Dwyer, Sharon Kelly and Leanne Geppert.

i. In principle support of the plan for closure of Barrett Adolescent Service with an understanding the new model of service is identified and developed.

172. This must mean what it says. Neither the Director-General nor the Deputy Director-General did more than give in principle support to the proposed closure of the Barrett Adolescent Centre.

15 July 2013 Meeting with the Minister for Health

173. On 15 July 2013, the Minister for Health met with Dr Corbett and Lesley Dwyer (**15 July 2013 Meeting**). Sharon Kelly was invited to attend the 15 July 2013 Meeting but did not. In anticipation of the 15 July 2013 Meeting, a Briefing Note for the Minister was prepared by Lesley Dwyer relevantly recommending that he:

Note *The West Moreton Board considered the recommendations of the Expert Clinical Reference Group on 24 May 2013, and approved the closure of the Barrett Adolescent Centre dependent on alternative, appropriate care provisions for the adolescent target group and the meeting with the Minister for Health.*

174. Both Ms Dwyer and Dr Corbett gave evidence that the Minister expressed support for the closure of the Barrett Adolescent Centre at 15 July 2013 Meeting. Ms Dwyer said that "the Minister for Health confirmed support for the closure of the [Barrett Adolescent Centre]". Dr Corbett's evidence is that:

The Minister for Health was supportive of the closure of BAC with a proposed date of 31 December 2013. The Minister requested:

(a) A communication plan and frequently asked questions be confirmed with his communications office.

(b) The Queensland Mental Health Commissioner be advised.

(c) The Leader of the Opposition be advised.

(d) The Director-General of the Department of Education be briefed prior to the announcement.

175. In a practical, if not a legal sense, the Closure Decision crystallised at this meeting. Importantly, Dr Kingswell was not involved in these meetings. His consent or approval was neither sought nor given. He of course would have supported a decision to close BAC, but he in fact did not participate in the decision to do so.

REASONS FOR THE CLOSURE OF THE BARRETT ADOLESCENT CENTRE

Uncontemporary model of care

176. The preponderance of evidence supports a finding that the model of care employed at the Barrett Adolescent Centre was uncontemporary. Given there is some controversy on this point, it is appropriate to set out the relevant evidence largely in full.

Professor David Crompton

177. Professor David Crompton gave evidence that:

> *the current service model being offered by the BAC was not considered to be a contemporary service and it did not meet the National Mental Health Service Planning Framework. However, the recommendations acknowledged that, in circumstances where BAC was to close, a Tier 3 extended treatment and rehabilitation facility should be made available in a timely manner.*
>
> *From my knowledge of the BAC facility, and given my experience as a Director of Mental Health, I was aware that:*
>
> *(a) the BAC was an old facility that was not purpose built as an adolescent mental health unit;*
>
> *(b) the BAC was in an area being redeveloped for high risk mental health consumers (including sexual offenders) and the continuation of BAC in its location could potentially place adolescent consumers at risk;*
>
> *(c) there had been some reviews conducted of the BAC facility in the past which from my recollection had suggested there was a need to consider more contemporary practices and that the facility needed to be updated;*
>
> *(d) there were length of stay issues at the BAC.*

> *I did have some concerns in relation to the Closure Decision, but those concerns mirror the type of concerns that I would have had upon the closure of any mental health facility. The Closure Decision having been made, my focus needed to be on seeking to ensure that there were appropriate services that would be available to replace the clinical care provided to the consumers that had previously been treated at BAC. In addition, any transition of care creates risks. Thus, I considered it appropriate to facilitate a meeting, discussed further below, that would bring people together so that the transition of consumers to Metro South could be done as smoothly as possible.*

Professor Brett McDermott

178. Professor Brett McDermott gave evidence that, contrary to the perception that he supported the Barrett Adolescent Centre model of care:

> *[M]y position was that I strongly supported the process of relocation of the BAC and hoped that a contemporary program and model of care would be delivered for the children of Queensland (as had been considered in the Redlands project and MOSD for AITRC process). My concern at that time was that that process might not occur.*
>
> *It is my view that with the BAC closure in January 2014 it was appropriate to replace it with another similar facility, with the caveat that the contemporary program elements identified in MOSD for AITRC process be embedded in the similar facility.*

179. With respect to the appropriate model of care for the Barrett Adolescent cohort, Professor McDermott gave the opinion that:

> *Much of the policy documentation relating to child and youth mental health has no direct impact on facilities such as the BAC. However, there are national and state principles that are clearly relevant. The most relevant, in my opinion, are the delivery of least restrictive care, access to services close to home, the overarching child and youth principle of developmentally appropriate services (that encourage normalisation rather than pathology), and a commitment to service evaluation.*
>
> *There is also literature on facilities being more effective if they are more "homelike" and less clinical in appearance and structure.*

> *Concerning least restrictive care, it is self-evident that day programs are less restrictive than inpatient facilities in that the former promotes the individual going to their home or to a homelike situation (foster-care or therapeutic residence) of an evening where they can put into practice therapy tasks and activities of the day. The BAC was restrictive by its nature as an inpatient unit, but also from its geographical isolation and placement on a large metal health campus.*
>
> *The principle of access to care close to home is not in favour of a state-wide long stay inpatient unit such as the BAC, which at times had patients from far nm1h Queensland, as well as central coast and other non-metropolitan areas.*

Dr Aaron Groves

180. Dr Groves' evidence was that, in the course of proceeding with the redevelopment of the Barrett Adolescent Centre:

> *Extensive consideration was given to changing the model of service; it needed major revision as it was out-dated and insufficiently integrated with the broader [Child and Youth Mental Health Services] system in Queensland.*

Timothy Eltham

181. Timothy Eltham's understanding of the reasons for the Closure Decision included the following:

> *The model of care at [the Barrett Adolescent Centre] consisted of long term institutionalised care in a centralised State-wide facility which for many patients meant they were disconnected from their family, friends, school, local community and other supports. Over a lengthy period, the philosophy of mental health care had moved away from institutionalised models and towards care in the community close to existing supports, where this was possible. The SAC model did not reflect current national or State based approaches, which emphasised care in the patient's local community and reduced reliance on hospitalisation. The closure of [the Barrett Adolescent Centre] was intended to reflect and occur in conjunction with the development of alternative service options which better reflected this contemporary approach to care.*

Dr Mary Corbett

182. Dr Mary Corbett (who is not a psychiatrist) was of the view that the model of care employed at the Barrett Adolescent Centre was "*not considered contemporary within the National Mental Health Service Planning Framework*", and was "*not considered consistent with the Queensland Plan for Mental Health either*".

Dr Leanne Geppert

183. Under examination by Counsel Assisting, Dr Leanne Geppert accepted that the "*Barrett Adolescent Centre was not a contemporary model of care*". With respect to the meaning of "contemporary", Dr Leanne Geppert said:

> *From my perspective – because I would like to make clear that there's probably great range of opinion across the mental health sector. From my perspective, a contemporary model of care is where you take into consideration the most recently developed policy platform, and that changes regularly at a national and state level. So being contemporary means that you would align models of service against those documents and repeatedly be checking back that you are actually in parallel with the agendas through those documents. For me, contemporary models of care in the setting around that period of time, the things that were considered contemporary were services and units that were wholly and comprehensively integrated with the rest of the continuum of care – so that's one really important thing. So that they didn't work in isolation, that they – there were linkages across the services, particularly across referring services both directions. But it was about other things as well like how you engage different parts of the mental health sector into the provision of care within those services. For example, non-government organisations was a really important part of the sector. But until the Queensland Plan for Mental Health, it is my understanding that – that their – those organisations did not play prominent roles in the provision of mental health care.*

Sharon Kelly

184. Sharon Kelly gave evidence that:

> *The information I had received from people as identified suggested that recreating the Barrett as it current was … not going to be contemporary. We*

> *needed to consider alternate options for providing services at that level close to home. Clearly there was not just a need in South East Queensland. So there was a need to make sure that we provided a really contemporary model where we can make sure that the adolescents could access services as close to home as was practical.*

185. Sharon Kelly sourced this information from "the Expert Clinical Reference Group coming forward and the people 45 on the planning group."

Dr Anthony O'Connell

186. Dr Anthony O'Connell's view was that:

> *The decision to close the [Barrett Adolescent Centre] is consistent with the principles espoused in the QPMH, namely establishing a statewide model of service, enhancing and developing the continuum of mental health treatment, giving emphasis to community-based care, better use of the Primary Care sector, promoting resilience and recovery, and better co-ordination of care.*

187. When asked by Counsel Assisting to say in what respects the Barrett Adolescent Centre was not a contemporary model of care, Dr Anthony O'Connell said:

> *It was a residential model that has a length of stay that was quite long; I think, you know, sort of, an average from about, I think, 10 months. But some of the clients had been involved with Barrett for about two years. That meant that, for many of them, there was a dislocation from their family and social networks, and from what I had been advised and had been able to read, that that is something that is not considered to be contemporary for that long period in time. I was also aware that [the] model that we had and particularly around the accommodation was also not what they would call a conducive, therapeutic environment.*

Lesley Dwyer

188. Lesley Dwyer gave evidence that she "*had concerns about the model of care which [the Barrett Adolescent Centre] represented.*"

> *Contemporary models of care are directed to providing care and support to patients in their local community in order to enable them to maintain established support networks and to engage or re-engage with their*

community as early as possible after acute inpatient treatment. In contrast to this, BAC involved a model of:

(a) Extended care which did not have rehabilitation as an element.

(b) Extended periods of dislocation from the patient's family, friends, school or other social networks in their local community.

(c) For patients who had progressed in their treatment and were relatively well, continued proximity to acutely unwell patients.

Professor Patrick McGorry

189. Properly understood, Professor McGorry's evidence does not support the Barrett Adolescent Centre model of care. First, the Professor said "*[the Barrett Adolescent Centre was] a stand-alone [facility] ... located in a heavily institutionalised and stigmatised settings, utilising what sounds like a typically old fashioned approach to such inpatient care.*" Plainly, this is not evidence which supports the Barrett Adolescent Centre model of care.

190. Secondly, while the Professor said "*there is a need for secure inpatient extended care*", the kind of facility which he had in mind was one which was a "*component of a broader suit of community services; for example accessible primary care, assertive community outreach, crisis assessment and treatment teams (CATT) and step-up/step down units.*" One of the problems with the Barrett Adolescent Centre model of care was that it was not closely linked with these community services. To the contrary, it was clinically isolated.

Dr Michelle Fryer (on behalf of the Royal Australian & New Zealand College of Psychiatrists)

191. Properly understood, Dr Fryer's evidence does not support the Barrett Adolescent Centre model of care. As Counsel Assisting rightly point out Dr Fryer gave evidence regarding facilities which provided "*inpatient stays a[t] a maximum of three to six months*". Accordingly, her evidence does not speak to the Barrett Adolescent Centre, which provided inpatient stays of up to a number of years. Accordingly, her evidence that "*the RANZCP supports consideration of a medium-term inpatient unit that provide[s] extended treatment and rehabilitation*" is not evidence in support of the Barrett Adolescent Centre. Further, Dr Fryer goes on to note that even facilities which provide inpatient stays that are only a matter of months pose risks. As Dr

Fryer says "*there are risks in models like these [ie models of care assuming inpatient stays of up to six months], such as: institutionalisation; delivering attention from community based models. Models that focus on minimising duration of stay while maximising therapeutic gains (generally cited at 3 to 6 months as a maximum) are preferable. There is concern that longer lengths of stay carry risks of deinstitutionalisation and iatrogenic increase in disability.*"

Professor Beth Kotzé

192. Professor Beth Kotzé was asked was the basis for her opinion that the Barrett Adolescent Centre was not considered to operate a contemporary model of care. Her response was as follows:

> *It wasn't my opinion. In developing the [National Mental Health Service Planning Framework], there was very detailed consideration of the evidence, but also models currently operating in the jurisdictions so that, for example, there was discussion about units in other states. There were presentations, for example, detailed presentations about some service units. There were site visits conducted by the project team to certain units. So it was during the process of those discussions, and a component of the planning process, which was looking at what was currently available, and, if you like, tagging them to particular categories of – of service within the taxonomy. It was during that process that I came to hear about the Barrett and to understand it was not operating on a contemporary model of care.*

193. In relation to whether the National Mental Health Service Planning Framework supported a bed-based service, Professor Kotzé's view was that it did, but subject to the following qualifications:

> *[T]he framework supports that there are some young people who would benefit from longer stays in hospital. Now, if you just take the Walker Unit, its average length of stay is in the order of 90 days. If you add the leave beds in, it's in the order of 135 days. But its median length of stay, so the middle point of the frequency distribution, is actually 42 days. So, in fact, it recognises – and – and that's recognised within the model. There are some young people who would benefit from that longer – longer stay. What the model – and – and that – and that's, really, most particularly young people with those enduring*

> *and relapsing mental illnesses like the psychoses and the affective disorders. What the model – what you won't find in the model is, for example, the very long lengths of stay under the Mental Health Act. You also will not find, for example, long length of stay for people with eating disorders. Now, you have to know where to find that in – in the model, but if you take that particular group you won't find that. You also won't find, for example, extended inpatient stay supported for the group of people who have strong emotional disregulation, which is the borderline personality disorder group in adult – in adulthood. You wouldn't actually go looking for that in this model. You would find that information, for example, from the NHMRC Guidelines for Borderline Personality Disorders. So there's quite a lot of unpicking that has to be done beneath the general statements.*

194. It is to be noted that Counsel Assisting submits that "*Professor Kotzé does not rule out the possibility of inpatient stays*". That may be true. But the relevant point is that, in her view, inpatient stays (in particular, long inpatient stays) are not to be preferred:

> *The best contemporary evidence supports that mental health care should be based in the community where young people live and are connected to their family, peers and community, with access to more intense levels of specialist day and inpatient care when it is not possible to provide the type or intensity of treatment or clinical risk management in a less restrictive setting. The phase of inpatient care should be as brief as possible to achieve symptom control and/or manage clinical risk and/or address significant disability with discharge to community-based care facilitated as soon as possible. This may require a period of intensive community-based care in the post-discharge period.*

Dr Kingswell

195. Dr Kingswell regarded the Barrett Adolescent Centre as operating an uncontemporary model of care:

> *[T]he centre had been operated as a therapeutic community for many years and, as such, it was a highly controversial and, some would argue, outdated, model of care. No other jurisdiction in Australia runs a centre where*

adolescents are hospitalised for years within a stand-alone psychiatric institution. A number of reviews over the years had recommended that the BAC be reformed or closed and replaced with alternative services but these had not been actioned.

These reviews included the following:

- *Barrett Adolescent Centre - Consultation on Aggression and Violence at the BAC, August 2003.*
- *Options Study for Barrett Adolescent Centre at The Park Centre for Mental Health, December 2004*
- *2009 Review of Barrett Adolescent Centre.*[51]

Evidence favouring the Barrett Adolescent Centre Model of Care is weak

196. As noted above, the ECRG Report recommended that a "*Tier 3 service should be prioritised to provide extended treatment and rehabilitation for adolescents with severe and persistent mental illness.*" That recommendation appears to have been treated as evidence that the ECRG Report supported the Barrett Adolescent Centre model of care. Several reasons militate against that inference.

197. First, it is not clear that the ECRG Report supported the construction of a Barrett-like *facility*. In this regard, it important to note that the ECRG Report recommends that a Tier 3 "*service*" is essential. That the ECRG Report repeatedly refers to a "*service*" rather than a "*facility*" is telling. It indicates that the ECRG Report actually recommended a comprehensive *system* of care, rather than the construction of a building. It is important in this context to recall the evidence of Amelia Callaghan, a member of the ECRG, who said:

> *the words tier 3 and inpatient are not the same thing. I think it is – and – and maybe it's my ignorance in misunderstanding the way terms are being used here but I – I think that there's clients that have a tier 3 need that can access, I would hope, in a fully developed model would be able to access services that could meet those needs without it being an inpatient unit.*
>
> *…*

[51] See also Statement of Dr Aaron Groves dated 21 January 2016 page 15 paragraph [85]-[86].

> *I have some concern that the words Barrett Adolescent Centre, tier 3 and inpatient are all being used interchangeably, so to say the Barrett Centre should or shouldn't have closed is not for me to say whether tier 3 should or shouldn't exist. I do think we need a tier 3 service. I'm not convinced that it needs to be an inpatient unit that – the type of the Barrett Adolescent Centre.*

198. This evidence gives the lie to Counsel Assisting's submission that "the ECRG was saying in clear terms that a tier 3 **facility** was essential" (my emphasis).

199. Secondly, ECRG Report notes that the ECRG was "*cognisant of constraints associated with funding and other resources (e.g. there is no capital funding available to build BAC on another site).*" This tells against the conclusion that the ECRG Report recommended the construction of a Barrett-like facility at Redlands.

200. Thirdly, the ECRG Report notes that the ECRG was *"mindful of the current policy context and direction for mental health services as informed by the National Mental Health Policy (2008) which articulates that 'non acute bed-based services should be community based wherever possible'.* This tells against the conclusion that the ECRG favoured an institutionalised model of care. As the ECRG Report goes on to state:

> *A key principle for child and youth mental health services, which is supported by all members of the ECRG, is that young people are treated in the least restrictive environment possible, and one which recognises the need for safety and cultural sensitivity, with the minimum possible disruption to family, educational, social and community networks.*

201. Fourthly, it is revealing that the ECRG Report cites the "*The Walker Unit*" as the example of the model of care the ECRG regarded as essential for patients of the Barrett Adolescent Centre. It is to be noted that the model of care employed by the Walker Unit is quite different from the model of care which was employed at the Barrett Adolescent Centre. As Dr Kingswell said:

> *The Barrett Adolescent Centre has no peer, so even the Walker Unit in New South Wales has a very different model of service. It tends to focus its attention on psychotic kids and it runs a duration of service of about six*

months.[52] *The Barrett Adolescent Centre, by contrast, ran a therapeutic community for a very disturbed group of adolescents that were predominantly engaged in very dangerous behaviours. And it kept them in that facility for periods of years.*

202. It is convenient at this point also to recall that Dr Groves' evidence was that:

> *The average length of stay for an adolescent as an inpatient in an acute [Child and Youth Mental Health Service] unit is usually measured in days and weeks and not months. This is important as for some people longer lengths of stay are associated with the potential development of institutionalised behaviours and for others it can be associated with age regression.*
>
> *Adolescents are at an important developmental stage of their life. Even those experiencing significant emotional and behavioural disturbance have an important need to be involved in making decisions about their life (this includes a wide range of things from deciding who are their friends, what they watch on television, remaining socially connected and what therapeutic or recreational programs they will undertake). The longer adolescents are kept away from home and friends the more likely unwanted effects can develop. This is one significant reason why the aim of child and youth inpatient services is to keep the length of stay to as short as is possible.*

203. Nowhere in the report or recommendations of the ECRG, nor in the evidence given by any of the members of it, can be found a recommendation for a single, stand-alone, state-wide long stay inpatient facility offering "Tier 3" components of service. If the ECRG had wanted to recommend that, it would have been a simple enough thing to say.

204. Professor Scott even gave evidence that he was not sure that even a Tier 3 service was any longer necessary.

> *Q. Now, Doctor, as I read the ECRG report, the ECRG report is fairly clear that a tier 3 facility was needed for this cohort of people. And is that still the case, in your view?*

[52] In this regard, note Professor Philip Hazel's evidence that "We chose six months because that's the median length of stay. Or for a long time it has been the median length of stay at Rivendell."

A. *I am less certain about – I think that there are possibly – there are other community models that operate around the world and other jurisdictions where there's specialist therapies available to provide care for young people in the community. As a rule, as an absolute rule, young people are best cared for at home with their families. So whenever that can take place, it should. What that often requires is extra disability support. It requires specialised and intensive therapy to be available in the community settings. And when those other services aren't available – and also extra educational support as well, schools being willing to look after these kids and educate these kids. When those aren't available, that's where we sort of find that young people can't be managed in a community and, thus, are needing an inpatient facility to look after them.*

...

I'm not strongly of a view that there should or shouldn't be a Tier 3 model in place. I think that people need to have a really good look at what the evidence is and what the other alternatives might be before investing such a large sum of money into such a facility.

Proximity to Extended Forensic Treatment and Rehabilitation Unit

205. Several witnesses were concerned that the proximity between the Extended Forensic Treatment Rehabilitation Unit and the Barrett Adolescent Centre posed an unacceptable risk that Barrett Centre patients may be harmed by adult forensic patients. Lesley Dwyer stated she was:

> *concerned about the appropriateness of co-locating vulnerable adolescents with patients with the index offences of some of the patients at The Park. Although stringent risk assessment processes were in place to evaluate whether and when to transfer high secure patients to lesser security arrangements, the risk presented by such patients cannot be completely eliminated. The planned commencement of the (EFTRU) and an incident in late 2012 when two patients of the High Secure unit absconded from The Park caused a close consideration of these risks and consolidated concerns that continued operation of BAC at The Park was not appropriate.*

206. This concern was shared by Dr Corbett who said that the whole West Moreton HHS Board "*was concerned about the safety and welfare of the BAC patients remaining on The Park campus once the EFTRU was operational*." [53] Ms Kelly understood that a chief reason why the Barrett Adolescent Centre closed was that "*the development of the EFTRU on the site … constituted an unacceptable level of risk to adolescents being accommodated in a low/no security environment on the site.*" [54] Dr Kingswell gave evidence the following evidence, which it is appropriate to set out in full:

> *I was concerned about the extended – the EFTRU, they call it, the Forensic Treatment Rehabilitation Unit, I think, that was to open onsite. I think this Inquiry has heard quite a lot of information that, in my view, is not true, that there was no risk posed to these adolescents that I'm sure you're aware that I was the director of forensic services for the southern half of the state for many years, up until about 2005. And I'd been working at Wolston Park since 1994. So I had a fair visibility of Barrett Adolescent Centre and other facilities on that site. The John Oxley Memorial Hospital which preceded the existing high secure unit used to admit 350 patients a year and 25 per cent of those patients were there in relation to fine default. So if the most dangerous thing you'd ever done was not pay a fine, nobody really cared and you could walk around the grounds and you probably didn't pose a risk to anybody much. That changed over time and particularly changed with the Mental Health Act 2000 which was proclaimed in 2002 which allowed mentally ill offenders to be managed in any mental health facility in the state that was prepared to accept the risk. And it constrained the activities of the high secure unit at The Park to only those people that had committed very serious offences; predominantly homicide, attempt homicide and other – you know, rape, very high level offending. The perimeter of the high secure unit is about five metres high and even the dog squad couldn't get over it. The EFTRU is a very different model of service. It's like a community care unit for mentally ill offenders. It's open. They can walk out. It has a gate. The likelihood of some harm coming to an adolescent on that site might not have been high and perhaps the immediacy wasn't urgent either, but the magnitude of the problem that you were going to*

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53 Corbett, [28.1]

54 Kelly, [11.11(b)]

visit if something went awry was going to be catastrophic, and had anything like that occurred I'd be sitting in front of an inquiry asking a – answering a very different set of questions. People would be asking what were you thinking leaving a group of vulnerable children on that site with that population?

207. Dr Kingswell's views ought be given particular weight, given his particular experience and expertise with forensic mental health matters. His views are, of course, thoroughly unremarkable in this respect. It could scarcely be doubted that accepting that the chance of an incident was low, the consequences would be likely to be catastrophic. In Dr Kingswell's view, that was not a risk that should be taken. There is no expert view given in evidence that contradicts that view.

Dr Sadler

208. Dr Kingswell gave evidence that one of the reasons why the Barrett Adolescent Centre was closed was that:

209.

TRANSITION ARRANGEMENTS

210. The extent of Dr Kingswell's involvement in the transition of patients of the Barrett Adolescent Centre included the provision of funding for the transfer of to the The relevant evidence on this

point is that there was a series of emails between Dr Anne Brennan, Elisabeth Hoehn, Sharon Kelly, Leanne Geppert, Dr Terry Stedman and others in December 2013 with respect to the transition of [redacted] This series of emails, as well as others, culminated in a request being made to Dr Kingswell, as Director of Mental Health, to provide funding for the provision of two nurses at the [redacted] Dr Kingswell regarded the request as a reasonable one, and the funding was provided.

211. It is worth noting that Dr Kingswell also assisted [redacted] in arranging care for [redacted] who had been a patient of the Barrett Adolescent Centre. Dr Kingswell gave evidence that the Department of Health continues to fund private psychological support for [redacted] and that [redacted] had advised that [redacted] was settling back into [redacted] local community where [redacted] is engaged in vocational training.

Adrian Duffy QC

Counsel for Dr Kingswell

23 March 2016