In the matter of the *Commissions of Inquiry Act 1950*

Commissions of Inquiry Order (No. 4) 2015

Barrett Adolescent Centre Commission of Inquiry

JOINT SUBMISSIONS FROM THE STATE OF QUEENSLAND, WEST MORETON HOSPITAL AND HEALTH SERVICE, METRO SOUTH HOSPITAL AND HEALTH SERVICE, METRO NORTH HOSPITAL AND HEALTH SERVICE RELATING TO CONFIDENTIALITY OF PATIENT RECORDS AND CLOSED HEARINGS

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Preamble

1. Prior to the first directions hearing, the following parties made a joint submission for orders pursuant to sections 16 and 16A of the *Commissions of Inquiry Act 1950* ("**COI ACT**"):

   (a) the State of Queensland;

   (b) West Moreton Hospital and Health Service ("**West Moreton**");

   (c) Metro South Hospital and Health Service ("**Metro South**");

   (d) Metro North Hospital and Health Service ("**Metro North**")

   (referred to jointly as "**the Applicants**").

2. A directions hearing was held on 15 October 2015, at which time the Commissioner made an Order to Prohibit Publication of Evidence under section 16 of the COI Act and adjourned for further consideration:

   (a) addition to the Order to Prohibit Publication of Evidence under section 16 of the COI Act of:

      (i) a paragraph relating to information under the *Disability Services Act 2006*, information the subject of Chapter 6 Part 6 of the *Child Protection Act 1999* and personal information collected under the *Education (General Provisions) Act 2006*;

      (ii) the following words to be inserted at the end of paragraph 1(b)(i):

      > which includes but is not limited to the following types of detail: gender, point in time, the person was an inpatient (or day patient), their clinical diagnosis and anything else relating to their clinical information or their family

   (b) the question of closed hearings; and

   (c) the consideration of the extension of confidentiality protection to current and previous Queensland Health staff who will be impacted by the Commission as raised in the letter from Dr Stephen Stathis[1].[2]

3. These joint submissions supplement the earlier joint submissions.[3]

Closed hearings

4. Section 16A of the *Commissions of Inquiry Act 1950* states:

> A commission shall not refuse to allow the public or any portion of the public to be present at any of the sittings of the commission unless in the opinion of the commission it is in the public interest expedient so to do for reasons connected with the subject matter of the inquiry or the nature of the evidence to be given.

[1] EXH.00001
[2] T2-8/L33 – T2-9/L16.
[3] SUB.00001.

5. The Terms of Reference require the Commission to make full and careful inquiry about, inter alia:

> 3(d) for BAC patients transitioned to alternative care arrangements in association with the closure or anticipated closure, whether before or after the closure announcement (***transition clients***):
>
> i. how care, support, service quality and safety risks were identified, assessed, planned for, managed and implemented before and after the closure (***transition arrangements***); and
>
> ii. the adequacy of the transition arrangements;
>
> 3(e) the adequacy of the care, support and services that were provided to the transition clients and their families;
>
> 3(f) the adequacy of support to BAC staff in relation to the closure and transitioning arrangements for transition clients;
>
> 3(i) whether any contraventions on the *Mental Health Act 2000* or other Acts, regulations or directives have occurred with regard to patient safety and confidentiality.

6. As such, the subject matter of the inquiry includes matters of sensitivity. This was recognised by the Commissioner at the first public sittings when the Commissioner observed:

> There is great sensitivity, legitimate sensitivity, about many of the issues the Commission must address including:
>
> - sensitivity because of the vulnerability of young people who suffer mental illness;
> - sensitivity because of the challenges young people's mental illness can present to their families, friends and carers;
> - sensitivity because of the varied demands their illness places on those engaged in their management whether they be medical practitioners, nurses, allied health workers, social workers, teachers, clerical workers or whoever; and
> - sensitivity because of community attitudes and concerns.[4]

Basis for the application

7. The reason for the requested order for closed hearings is to protect transition patients and previous patients of the Barrett Adolescent Centre, and other at-risk individuals within the community who may self-identify with self-harm/suicide (otherwise known as "copycat" self-harm / suicide).

[4] T1-5/L10-20.

8. In this respect, the Applicants continue to rely on the reports attached to the earlier joint submissions, being reports from:

   (a) Associate Professor John Allan, Chief Psychiatrist, Mental Health, Alcohol and Other Drugs Branch, Queensland Health;

   (b) Dr William Kingswell, Executive Director, Mental Health, Alcohol and Other Drugs Branch, Queensland Health;

   (c) Dr Andrew Aboud, Clinical Director, Prison Mental Health Services, The Park – Centre for Mental Health, West Moreton Hospital and Health Service;

   (d) Dr Sean Hatherill, Clinical Director, Metro South Child and Youth Academic Clinical Unit; and

   (e) Associate Professor James Scott, Child and Adolescent Psychiatrist, Royal Brisbane and Women's Hospital.

9. The Applicants also rely on the report from Dr Stephen Stathis, Medical Director, Child and Youth Mental Health Service tendered at the directions hearing on 15 October 2015.[5]

10. These expert reports are from clinicians qualified and experienced in the field of adolescent psychiatry who were commissioned to express their opinions on the risks to past patients of the Barrett Adolescent Centre and at risk youth generally of:

   (a) the conduct of public hearings in this Inquiry (including web streaming of those hearings); as well as

   (b) media publication of matters relating to the patients who are the subject of the terms of reference of this Inquiry; and

   (c) public disclosure of confidential personal medical records.

[5] EXH.00001.

11. The following extracts from the expert evidence (contained within the earlier submissions) continue to have relevance and bear repeating:

(a) Report of Dr Hatherill:

> 7. I have a concern about the impact of public, web-streamed hearings, relating to recent youth suicides on both the young people who were transitioned out of the BAC and the wider youth community.
>
> 8. [redacted]
>
> 9. As we approach the anniversary of the closure of the BAC, I have concerns in relation to the deleterious impact on those young people's mental state and the risk of suicide contagion effects if they are exposed to media coverage or web streaming of the Commission hearings.
>
> 10. I also have some concerns in relation to the disclosure of confidential personal medical records of the young people who were patients of the Barrett Adolescent Centre. Even with the best attempts to de-identify records, much of the information contained in these records may still be identifiable to the young people themselves, family and friends. Information contained in these personal records may well be exquisitely sensitive, relating to histories of trauma, neglect, abuse, and personal experiences hopelessness and suicidal thinking. My concern is that disclosure of these records, even in the de-identified format, may have the potential to destabilise the mental states of the young people concerned, and may also have a deleterious effect on the family members.
>
> 11. While I have particular concerns for those young persons transitioned from the BAC, I also have a concern in relation to the risk of suicide contagion effects in the wider youth community if the media coverage is not very carefully managed or if there is publicly accessible web streaming. The potential for youth suicide contagious effects is a real, well documented risk. In that respect I refer to the following:
>
> (a) Gould, M, Jamieson, P, and Romer, D. Media Contagion and Suicide Among the Young. American Behavioural Scientist, May 2003; Vol. 46 N. 9, 1269 - 1284 (copy **attached** as annexure 2 to Dr Hatherill's report); and
>
> (b) Abrutyn, S and Mueller, A. Are Suicide Behaviours Contagious in Adolescence? Using Longitudinal Data to Examine Suicide Suggestion. American Sociological Review, 2014, Vol 79(2) 211-227 (copy **attached** as annexure 3 to Dr Hatheril's report).

(b) Report of Associate Professor James Scott:

1. As a result of any inquiry, it is impossible to predict the responses of patients who received care whilst in the Barrett Centre and their families. It is likely that whilst the inquiry may bring relief to some individuals, it will engender distress in others.
2. Following the closure of the Barrett Centre, information of the suicides and attempts of suicide was widely disseminated through social media as well as mainstream media.
3. [redacted]
4. On the balance of probabilities, the planned inquiry and dissemination of information arising from a hearing will likely cause distress in some patients and their families which may result in serious psychological harm.
5. In view of this risk, any inquiry into the closure of the Barrett Centre should handle information with the utmost sensitivity.
6. Information about any individual patients should be kept confidential.
7. It is unclear how other aspects of the inquiry best be managed. Clearly it is paramount that support is available for the patients who received treatment at the Barrett Centre and their families whilst this inquiry is undertaken so as to minimise the risk of psychological harm and suicide.

(c) Report of Dr Andrew Aboud:

I recognise the potential concern that has been highlighted by West Moreton Hospital and Health Board about the potential effect, which disclosure and publicity of certain matters through the inquiry process may have on former Barrett Adolescent Centre (BAC) patients, their families and others. These effects may occur in the context of: patient confidentially not being maintained; public hearings (including web streaming); media publication of matters relating to the patients who are the subject of the terms of reference.

... For some of these individuals, in particular former BAC patients, the inquiry process may be quite stressful and even lead to an increase in self-harm behaviour and suicidal urge. Compromised confidentiality may potentially make this process more traumatic and increase the risks. Those with pre-existing mental health problems will be most vulnerable, yet so might those without pre-existing mental problems, but harbouring risk factors for such.

It is important to be aware that de-identification may not achieve true anonymity for individuals and sensitive material. Individuals and families and associates may well be able to identify such persons, based on material presented.

...

It is my opinion that mechanisms should be put in place to: protect patient confidentiality; minimise potential risk to current patients, and other persons who were contemporary patients of those the subject of the terms of reference; minimise the potential for "copycat" self-harm/suicide by others at risk within our community. In my view such mechanisms would include holding closed, as opposed to open, court hearings and also consideration of placing appropriate boundaries on media reporting.

(d) Report of Dr William John Kingswell:

In my view [closed hearings] is critically important. As you know there is a literature that supports an association between media reporting of suicide and self-harm and a copycat or contagion effect. While I believe that is a risk, the more important risk is that sensitive personal and clinical information will be exposed in the public space. The BAC catered to a very small cohort and individuals will be readily identifiable amongst former patients, families and staff but also more broadly within the community. Some of these clinical records will note very sensitive information such as a history of physical or sexual abuse.

The population accessing the BAC was particularly vulnerable to stress as evidenced by the three suicides that precipitated this inquiry. Public exposure of a young person's medical and personal record and information provided by family carers and staff of a clinical or personal nature will be potentially highly embarrassing and stressful and worsen their already poor mental health and place the young person at risk of deliberate self-harm or suicide.

(e) Report of Associate Professor John Allan:

Concerns about copycat suicide stimulated by media coverage have been present for many years and there is now considerable evidence relating to this. Mindframe, an Australian national media initiative which has been operating within the Hunter Institute of Mental Health for greater than 10 years, was set up particularly to address these issues. ... They suggest "There is strong support for the relationship between media reporting of suicide deaths and increases in completed and attempted suicide rates". ...

There is also evidence that certain groups may be more vulnerable e.g. when the person identifies with the person who suicided, in young people, or when the person is already experiencing mental health issues. An important review, Suicide and the news and information media by Australians Jane Pirkis and Warwick Blood (2010) concluded that presentations of suicide in news and information media can influence copycat acts in circumstances such as "irresponsible" presentations in news and information media. They also note that suicide is a behaviour which is susceptible imitation which leads to suicide "clusters". "Clusters" may be another way of describing "copycat" events but usually refers to a group of suicide events that are in a limited geographical area or cultural subgroup. In Australia concerns have been raised about cluster suicides in groups of young people and particularly young indigenous people.

There is also evidence that explicit descriptions of methods and places of suicide have led to increased suicide rates. Another report suggested that media depicting real suicide events rather than fictionalised ones can lead to a higher increase in rate. These are things that are likely to arise in the Commission's deliberations.

...

Even with de-identification of witnesses and material there remain risks of potential self-identification with the suicide described, particularly by young people who have an existing mental health condition or who have previously been patients of that particular or any other mental health service. My conclusion is therefore that the evidence suggests there is an increased risk of copycat behaviour amongst vulnerable young people from the press coverage and particularly if the reporting is insensitive or sensationalised.

For persons with a mental health history who are appearing in the Inquiry, the stress could lead to deterioration in their mental state. I assume that any current or former patients and their family giving evidence will have access to dedicated concurrent and ongoing psychiatric support to deal with this. I want to point out however that publication of their stories can increase this stress even if de-identified. ..... the community of patients and families whose stories may be aired in this Inquiry is small and many know each other. Working out who is who may be much easier for those with some knowledge than the general public. It is likely that not everyone whose case will be examined in the Inquiry will welcome public scrutiny. The chances of further traumatisation by publicity similarly remain high.

It is also possible that former patients who hear reports of other's experiences may both identify with those stories and increase their risk or may misidentify the stories as their own and then feel aggrieved that their story is in the press.

My opinion is that the best way to protect this group of people would be for closed court hearing and limitations on media publications.

... Given the sensitivities for individuals and the potential risk, limitations around reporting on individuals and guidelines around sensible reporting of the general issues would be essential. Closed sessions where appropriate would decrease the risk of poor social media coverage.

Closed hearings for those affected would be very important in protecting the mental health of participants. Serious consideration needs to be given to the potential harmful effects on vulnerable people of uncontrolled or sensational reporting.

(f) Report of Dr Stephen Stathis:

1. In line with the proposal that has been contributed by my colleagues, Associate Professor John Allan, Dr William Kingswell, Dr Andrew Aboud, Dr Sean Hatherill, and Associate Professor James Scott, I concur with their clinical opinions regarding their applications for non-publication orders and to conduct closed hearings.

2. As it progresses, evidence provided to the Commission may contribute to distress in some patients and their families which conceivably could result in serious psychological and physical harm.

3. In view of this risk, it is important that this entire process should manage information security with utmost sensitivity.

4. Patients and their families are entitled to have their clinical records kept confidential. I echo my peers' advocacy that the Commission

> should do everything possible to prevent any publication of content that could conceivably impact their privacy. This cohort of patients and their families are a vulnerable group, and their ongoing health could be detrimentally impacted through any form of publication.
>
> ...
>
> 9. Further, the Commission has the potential to conduct hearings in public with the additional live streaming of content via the Internet. It is, in my clinical opinion, an equitable risk to patients, families and staff, to be easily identified and persecuted outside the realm of this Commission of Inquiry.

12. In addition, the Applicants request that the Commissioner consider the CIMHA records of the patients provided to the Commission in response to a Notice to Produce addressed to the Director-General of the Department of Health dated 14 September 2015.

Submissions

13. The importance of public hearings as "*a means of restoring public confidence, and as a means of independent scrutiny, into those areas of government administration where a problem has arisen*" is noted.[6]

14. However, given the concerns expressed by the expert clinicians, it is "*in the public interest expedient*" to conduct the hearings *in camera* given the risks arising from public ventilation of the subject matter.

15. As is mentioned above, pursuant to section 16A of the COI Act, sittings of a commission are to be public unless, in the opinion of the Commissioner, it is in the public interest expedient to close the sitting:

    (a) for reasons connected with the subject matter of the inquiry; or

    (b) for reasons connected with the nature of the evidence to be given.

16. Each of the Applicants will provide individual submissions with respect to the nature of the evidence to be given by each of their witnesses (and, to the extent possible, the evidence sought to be explored in cross-examination) to identify with more particularity those witnesses for whose evidence it is submitted the hearings ought be closed (either wholly or in part).

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[6] Hallett, L, "Royal Commissions and Boards of Inquiry", The Law Book Company Limited, 1982, 173.

17. In general, it is the joint submission of the Applicants that, to the extent that evidence of the witnesses will traverse the following subject matter, the hearings ought be closed:

    (a) information regarding a patient's health, including but not limited to information contained in their medical and clinical records;

    (b) information that identifies, or is likely to lead to the identification of a patient or former patient of the Barrett Adolescent Centre or their family, which includes but is not limited to the following types of detail: gender, date of birth, home address/es or geographic location, point in time the person was an inpatient (or day patient), treating clinician, patient specific transition arrangements including the location or name of the receiving service, patients' clinical diagnosis and anything else relating to their clinical information or their family;

    (c) details of the method or location of the death of any deceased patient; and

    (d) details of the fact of and/or method of any incidents of self-harm.

18. Given the small cohort of transition patients, the nature of their information is such that their identity (and consequentially their medical and clinical information and personal circumstances) cannot adequately be protected by the use of code names or redaction of patients' names.

19. It is submitted that any public disclosure of the nature of information referred to in paragraph 17 above carries with it a perceptible risk of adverse harm to those patients and adverse impact on their ongoing care and treatment.

Expansion of non-publication orders

20. Section 16 of the COI Act provides:

> A commission may order that any evidence given before it, or the contents of any book, document, writing or record produced at the inquiry, shall not be published.

21. As is mentioned above, on 15 October 2015 an Order to Prohibit Publication of Evidence was made under section 16 of the COI Act.

22. The Applicants jointly submit that the Order ought be amended to:

(a) insert a paragraph relating to information under the *Disability Services Act 2006*, information the subject of Chapter 6 Part 6 of the *Child Protection Act 1999* and personal information under section 426 of the *Education (General Provisions) Act 2006*;

(b) insert the following words at the end of paragraph 1(b)(i):

> which includes but is not limited to the following types of detail: gender, date of birth, home address/es or geographic location, point in time the person was an inpatient (or day patient), treating clinician, patient specific transition arrangements including the location or name of the receiving service, the patients' clinical diagnosis and anything else relating to their clinical information or their family.

(c) insert the words "*or location*" after the word '*method*' at paragraph 1(b)(iii).

23. These additional words are necessary, given the small cohort of transition patients, the nature of the patient information is such that their identity (and consequentially their medical and clinical information and personal circumstances) cannot adequately be protected by the use of code names or redaction of patient names alone.

24. The publication of information under the *Disability Services Act 2006*, information the subject of Chapter 6 Part 6 of the *Child Protection Act 1999* and personal information under section 426 of the *Education (General Provisions) Act 2006*, is information of a nature that is likely to lead to the identification of patients if published.

25. In the circumstances, it is submitted that the proposed amendments are an appropriate exercise of the Commissioner's discretion.

Extension of confidentiality protection to staff

26. Each of the Applicants will provide individual submissions, to the extent considered appropriate, with respect to confidentiality protection of particular staff.

Non-publication of these submissions and closed directions hearing

27. The Applicants request that these submissions not be published without redaction.

28. The Applicants also note that there may be a need for part of the directions hearing to be closed if detailed oral submissions are necessary.

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