ASSISTING COUNSELS' CLOSING SUBMISSIONS

PART A: INTRODUCTION

1. There are four real issues.

The First/Fundamental Issue

2. The first is a fundamental issue: Was there, and is there, a need for a facility like the Barrett Adolescent Centre (the BAC) or its proposed replacement at Redlands?

3. One view is that the BAC cohort, and those on the waiting list, were readily able to be absorbed into existing health services; another is that the new suite of services, such as the Lady Cilento 'swing' beds and/or AMYOS teams, make it now a different situation to January 2014; and some, but not all, of the BAC's harshest critics seem to see a need for something in its place.

4. And so at the core of this inquiry is this fundamental issue: by what sort of services should we look after vulnerable young people like these?

Pro-Barrett v Anti-Barrett

5. In our opening address, we warned against viewing the issues and the evidence through a 'pro-Barrett' or 'anti-Barrett' prism. On the one hand, the BAC had its passionate supporters. Some parents described the BAC as their last resort. On the other hand, some reports of the BAC were critical of both the building and the operation of this health service. Some say that the BAC was isolated both geographically and clinically. No doubt both sides of that argument can mount powerful arguments.

6. That was, and still is, a stale debate. The BAC was to be replaced – with, it seems, a new building adjacent to the Redlands Hospital and with a new, up-graded model of care and, almost certainly, mostly new staff. In that context, it makes little sense to debate whether the BAC provided good, bad or indifferent treatment.

7. The important issue is not the specific merits of the BAC as a health service, but rather whether there was, and still is, a need for a BAC/Redlands/Tier 3 type of facility.

The Second Real Issue – Sub-Acute Patients in Acute Wards

8. The second real issue, and it is an issue related to the first, is this; can the vulnerable young people with severe, persistent mental illness be accommodated in a facility such as the Lady Cilento Acute Adolescent Mental Health unit.

9. In other words, can sub-acute adolescent patients be accommodated in an acute ward?

The Third Issue – The Decision-Making Process

10. The third real issue is this; if there is in fact a need for a BAC/Redlands/Tier 3 type of facility, another decision-making process issue arises. That process issue is; how did we get to the point where no similar extended treatment facility is available to the young people who, before January 2014, would have been treated by the BAC? In other words, what were the reasons for getting to this point and can we do this type of decision-making better?

11. On that third issue (the process issue), the briefing notes and the board decision of 24 May 2013 – the decision documents - often contain headings like “Headline Issues” and “Key Issues” and “Communication Plan”. Those documents are concerned with abbreviating the decision-making process, and ensuring it is smoothly communicated. There seemed to be little emphasis on ensuring that the decision is the correct or best decision and is supported by proper and detailed analysis. The result is that the decisions made in this case appear to be based, not on any sound factual foundation, but rather on the unstable foundations of unattributed conversations and abbreviated or shorthand expressions. The expression “contemporary models of care” is an example.

12. The fourth real issue is whether the transition arrangements were adequate. That has a number of different aspects to it which are considered below.

PART B: THE FIRST & FUNDAMENTAL ISSUE – TIER 3?

13. The first fundamental issue is this; was there, and is there still, a need for a facility like the BAC or its proposed replacement at Redlands?

The Experts

14. This Commission had the considerable advantage of hearing from a number of highly qualified child and adolescent psychiatrists, each of whom have many years of experience in the field.

15. There were no significant differences in their views. The views of those experts can be summarised below. It is worth giving additional weight to the child and adolescent psychiatrists, such as Dr Scott and Professor Hazell, with direct clinical experience with adolescents aged between 13 and 17 years of age with severe, persistent mental illness.

Dr Scott

16. Dr Scott's statement includes this passage:

> *"I was personally concerned about the possibility of the BAC being closed because I recognised it to be the only long-stay inpatient facility for adolescents in Queensland. Without the BAC, there was nothing else available at that time for patients who had severe mental health problems that could not be managed in the community."*[1]

17. In a letter to the Minister, Dr Scott explained his concerns that:

> *"(a) without the BAC, there would be an enormous gap in care;*
>
> *(b) acute inpatient units cannot provide the same care as the BAC as they are driven by performance indicators such as short lengths of stay, and the mental health problems that trouble adolescents admitted to the BAC will not respond to brief admissions and existing community care; and*

[1] Exhibit 114, Statement of James Scott, 4 February 2016, p 6 para 28 [MNH.900.003.0001] at [.0006].

(c) *the BAC plays an important role in preventing young people from suicidal acts or committing offences that result in lengthy incarceration."*[2]

18. Dr Scott thought the facility was crucial:

"*Knowing the patients who I had referred to the BAC, I was firmly of the view that without high level care such as the BAC, it was probable or at the very least possible, that some of them would die. Of course, a feature of the cohort of adolescents treated at the BAC is that many have high levels of suicide*."[3]

19. As Dr Scott points out:

"The ECRG expressed a view that a tier 3 level of care was needed. This was in part because the group was not aware of any other options other than the existing care options that had historically been available in Queensland and what had been proposed, particularly with the ECRG agreeing that reliance on acute inpatient facilities was not appropriate for this group of adolescents with severe and complex needs."[4]

20. In his oral evidence, Dr Scott explained that:

"*I think the – there still remains a small proportion of persons who have persistent eating disorders or persistent psychotic disorders or persistent mood disorders that can't be supported in day programs, and the other options which you've discussed and such*."[5]

21. Dr Scott stated in his evidence that as an absolute rule young people are best cared for at home with their families. However, this requires a range of services to be available in the community; for example, disability support, specialised and intensive therapy and extra educational support. When those services are not available in the community, young people need an inpatient facility to address their needs.[6]

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2 Exhibit 114, Statement of James Scott, 4 February 2016, p 7 para 32 [MNH.900.003.0001] at [.0007].
3 Exhibit 114, Statement of James Scott, 4 February 2016, p 11 para 65 [MNH.900.003.0001] at [.0011].
4 Exhibit 114, Statement of James Scott, 4 February 2016, pp 11–12 para 66 [MNH.900.003.0001] at [.0011].
5 Transcript, James Scott, 17 February 2016, p 8-13 lines 8–11.
6 Transcript, James Scott, 17 February 2016, p 8-8 lines 29–41.

22. Dr Scott reiterated that:

> "*acute inpatient units cannot provide the same care as the BAC as they are driven by performance indicators such as short lengths of stay and the mental health problems that trouble adolescents admitted to the BAC will not respond to brief admissions and existing community care"*.[7]

23. The ECRG, of which Dr Scott was a member, expressed the view that a tier 3 level of care was essential. This was partly because the group was not aware of any other existing care options available in Queensland and reliance on acute inpatient facilities was not appropriate for this group of adolescents with severe and complex needs.[8]

24. Dr Scott's oral evidence was that the members of the ECRG unanimously supported a tier 3 option in the recommended service model.[9] He stated that the members of the ECRG required a tier 3 service as they were concerned by the prospect of not having a replacement centre for the BAC.[10] Dr Scott stated that:

> *"I consider mental health care must necessarily be accompanied by a meaningful partnership of services from other government departments (including health, child safety, education, housing etc), Non-Government Organisations and potentially the private sector. In my experience, currently this wraparound care is generally done poorly in Queensland."*[11]

25. When cross examined by Mr Harper about whether it was beneficial to continue to provide a tier 3 service in the future, Dr Scott stated "…I'm not strongly of a view that there should be 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.*"*[12]

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7 Exhibit 114, Statement of James Scott, 4 February 2016, p 7 para 32(b) [MNH.900.003.0001] at [.0007].
8 Exhibit 114, Statement of James Scott, 4 February 2016, pp 11–12 para 66 [MNH.900.003.0001] at [.0011]-[.0012].
9 Transcript, James Scott, 17 February 2016, p 8-6 line 1; p 8-6 line 44; p 8-6 line 45 – 8-7 line 4.
10 Transcript, James Scott, 17 February 2016, p 8-7 lines 6–10.
11 Exhibit 114, Statement of James Scott, 4 February 2016, para 83 [MNH.900.003.0001] at [.0015].
12 Transcript, James Scott, 17 February 2016, p 8-27 lines 28–31.

Professor Hazell

26. Professor Hazell, also a member of the ECRG, remained supportive of the recommendation of the ECRG that inpatient extended treatment and rehabilitation care (Tier 3) was an essential service component.[13]

27. He explained:

> *"For a state the size of Queensland, I consider that a lack of a Tier 3 service for adolescents will create difficulties and put pressure on the other levels of service, including 'bed block' for acute inpatient units."*[14]

> *"Facilities such as the Walker unit and the BAC are important in any statewide mental health service, in order to take away the demands from the acute units."*[15]

28. Professor Hazell believed that the ECRG did not take a tier 3 option 'off the table'. He interpreted it as removing an option to build a new building, but refurbishing an existing facility or finding alternative accommodation for the service.[16] He agreed that adolescents requiring more intensive services than possible from a tier 3 service would not have their needs met by a tier 2 service.[17]

29. He warned the Commission of the risk of replacement services with subacute beds in an acute setting (such as at the Lady Cilento and Mater Hospital) stating:

> *"So with our severe and persistently unwell patients, we're trying as hard as we can to get them to a stable state where there's not too much fluctuation in their emotional regulation and their behaviour, but because of the nature of their illnesses they're still quite vulnerable and brittle. The experience in an acute unit is that every time you introduce a new acutely unwell patient you destabilise the longer-term patients."*[18]

30. He had strong views on alternatives to a tier 3 service, for example:

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13 Exhibit 63, Statement of Philip Hazell, 5 November 2015, para 77 [WIT.900.005.0001] at [.0014].
14 Exhibit 63, Statement of Philip Hazell, 5 November 2015, para 78 [WIT.900.005.0001] at [.0014].
15 Exhibit 63, Statement of Philip Hazell, 5 November 2015, para 94 [WIT.900.005.0001] at [.0016].
16 Transcript, Philip Hazell, 17 February 2016, p 8-33 lines 32–36.
17 Transcript, Philip Hazell, 17 February 2016, p 8-35 lines 1–26.
18 Transcript, Philip Hazell, 17 February 2016, p 8-37 lines 42–47.

(a) *Assertive community treatment/outreach:* These programs do have a place in the continuum of care, however, they do not play a role in persistent/treatment-resistant mental health illnesses. These programs are crisis orientated and as a result are not helpful for a patient whose mental health illness is chronic.

(b) *Day programs:* In order for these programs to work, the patient must first have a stable base. As a result, they are not helpful for patient's whose mental health issues are severe.

(c) *Residential treatment units (non-hospital):* He does not agree with the residential treatment units being suggested as an option in the ECRG report. The basis for his position is that care is not being provided by clinical staff. He considers it important that clinical staff be involved in the provision of care, for example, monitoring of medication and counselling.

(d) *Wraparound services and other types of intensive care management:* He considers them to be effective, however not for patients whose mental health issues are severe and persistent.

(e) *Family preservation/intensive home treatment:* This model of care is effective, however, not for a group of patients whose mental health issues are severe and persistent.[19]

31. Importantly, Professor Hazell believed there are a lack of services in the community, stating:

> *"There is unmet need in the community. There is unmet need for mental health problems right across the age span. There are particular risks in transition between particular age groups to the next and a major risk area is the transition between adolescence and adulthood. I wouldn't characterise that as necessarily a gap but more as a challenge."*[20]

32. Professor Hazell recommended that the best model of care and system of care for adolescents would include the following factors:

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19 Exhibit 63, Statement of Philip Hazell, 5 November 2015, para 98 [WIT.900.005.0001] at [.0017]-[.0018].

20 Transcript, Philip Hazell, 17 February 2016, p 8-40 lines 3–7.

> *"(a) a continuum of services at differing levels (one of which is a facility such as the BAC or the Walker unit);*
>
> *(b) allow patients to move seamlessly in and out of services along the continuum;*
>
> *(c) is mindful of the developmental stages of an adolescent patient, as well as the severity and phase of their illness;*
>
> *(d) builds in components that ensure the maintenance of patient physical and mental health and optimises education; and*
>
> *(e) maintenance of contact between the patient and their supports (family/carer).'*[21]

Professor McGorry

33. In Professor McGorry's statement he said he believed that inpatient facilities focusing on extended care and rehabilitation for severe and persistent illnesses are necessary and more so in Queensland because of the population and demography.[22]

34. Professor McGorry commented on the proposed Redlands facility. He stated that "there is a need for secure inpatient extended care as a last resort option for emerging adults who are damaged, disabled, developmentally regressed and disconnected, that other treatment options have failed". Furthermore, he explained that this facility must be one component of a broader suite of community services; for example, accessible primary care, assertive community outreach, crisis assessment and treatment teams (CATT), and step-up/step down units.[23]

35. Professor McGorry was asked to comment on the appropriateness of closing a sub-acute extended and rehabilitation service (i.e. the BAC) before a replacement model of care was finalised. He responded:

> *"Closing a facility caring for the most severely ill and disabled without an alternative approach is a microcosm of the kind of irresponsible deinstitutionalisation that has plagued mental health reform over the past 3*

21 Exhibit 63, Statement of Philip Hazell, 5 November 2015, para 97 [WIT.900.005.0001] at [.0017].
22 Exhibit 86, Statement of Patrick McGorry, 3 February 2016, para 47 [WIT.900.019.0001] at [.0015].
23 Exhibit 86, Statement of Patrick McGorry, 3 February 2016, para 52 [WIT.900.019.0001] at [.0016].

decades around the world. Not only must a suite of alternatives be put in place, not merely a one for one replacement, there is a wider imperative for Queensland to invest in and develop a restructured and expanded stream of care for the 12-25 year olds that represent the future of the State and to safeguard this future in so doing."[24]

36. That statement speaks for itself, demonstrating that a tier 3 service, such as the BAC, needs appropriate alternatives in place to adequately support young people suffering from mental illness.

37. Professor McGorry stated that, based on prevailing philosophy of emerging adult mental health, community-based treatment is more beneficial than long-term inpatient care. This is because long-term inpatient care can lead to institutionalisation. On the other hand, Professor McGorry stated that for a cohort similar to the BAC (severely damaged patients), longer inpatient admissions are necessary and need to be available.[25]

38. Professor McGorry made a number of recommendations for care being provided in Queensland, including:

    (a) If a tier 3 service is built, other adjunctive community services would need to be closely embedded and linked into the facility. This may counteract the risk of the patients becoming idiosyncratic, institutionalised and otherwise isolated.[26] However, he summarised the BAC model as a "stand-alone and located in a heavily institutionalized and stigmatized settings, utilising what sounds like a typically old fashioned approach to such inpatient care*"*.[27]

    (b) For a cohort like the BAC cohort, everything from primary care through to specialised tertiary facilities and more is needed.[28] Community supports, including supported residential services, need to be available. Without this kind of intensive

[24] Exhibit 86, Statement of Patrick McGorry, 3 February 2016, para 56 [WIT.900.019.0001] at [.0016]-[.0017].
[25] Exhibit 86, Statement of Patrick McGorry, 3 February 2016, para 39 [WIT.900.019.0001] at [.0012]-[.0013].
[26] Exhibit 86, Statement of Patrick McGorry, 3 February 2016, para 49 [WIT.900.019.0001] at [.0015].
[27] Exhibit 86, Statement of Patrick McGorry, 3 February 2016, para 48 [WIT.900.019.0001] at [.0015].
[28] Transcript, Patrick McGorry, 2 March 2016, p 18-3 lines 36–41.

support patients are likely to be in jail, homeless or dead within a short period of time.[29]

(c) Acute inpatient facilities must provide a "haven" for patients in a relaxed and calm environment. Professor McGorry considers that even youth-friendly acute units are highly stressful environments.[30]

(d) The age of the patient should be taken into account on deciding whether they can access the service. Professor McGorry suggests that patients aged 12 to 25 should still be able to access the same inpatient facility. However, it would be necessary for the centre to be designed so that the appropriate age and gender demarcations are respected and maintained.[31]

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

39. It is important to first clarify Dr Fryer's definition of medium term stay and long term stay as this changes the perspective on her views about the BAC being an adequate facility for adolescents. Dr Fryer defines these medium inpatient stays as a maximum of three to six months.[32] She gave evidence that there is no professional definition of "long stay".[33]

40. Dr Fryer was questioned about whether it is possible to put a time limit on the expression "medium-term" stay:

> "*It's very difficult to put a figure on especially for this group. One needs to be responsive to their needs but also have careful consideration of not just the benefits or potential benefits but also the potential risks of any intervention that's undertaken.*"[34]

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29 Exhibit 86, Statement of Patrick McGorry, 3 February 2016, para 39 [WIT.900.019.0001] at [.0012]-[.0013].
30 Exhibit 86, Statement of Patrick McGorry, 3 February 2016, para 54 [WIT.900.019.0001] at [.0016].
31 Exhibit 86, Statement of Patrick McGorry, 3 February 2016, para 50 [WIT.900.019.0001] at [.0015].
32 Exhibit 288, Supplementary submission from the Royal Australian & New Zealand College of Psychiatrists [RAN.001.0002.0001]; Transcript, Michelle Fryer, 11 March 2016, p 25-12 lines 26–42.
33 Transcript, Michelle Fryer, 11 March 2016, p 25-12 lines 23–24
34 Transcript, Michelle Fryer, 11 March 2016, p 25-12 lines 26–42.

41. In her first report, Dr Fryer said that: "there is no evidence that long stay adolescent units are effective or cost effective. It is acknowledged that a lack of evidence is not evidence that long stay hospitalisations are not effective."[35] Importantly, she acknowledged that a lack of evidence in this area is not evidence that long stay hospitalisations are not effective. She confirmed in oral evidence that this lack of evidence for long stay treatment related to adolescents with the most severe conditions.[36] On the other hand, she acknowledged the specific needs of the patients and saw value in what the BAC offered:

> *"…some of the patients previously referred or considered for referral needed specific aspects of what BAC offered, such as safe, therapeutic accommodation or specialist schooling that could accommodate the impact of major mental illness such as psychosis. Even considering the group that have benefitted, in the light of the current practice and evidence base, I wonder if more intensive community services could have met their needs."*[37]

42. In oral evidence, Dr Fryer was asked whether the BAC cohort (patients requiring a long term or medium term inpatient service) could be treated in an acute unit. Her response was:

> *"As the Commission has heard, those – the needs of those patients are different to acutely unwell patients where there's very much a focus on stabilisation of mental state, institution of often but not always medication and the correct treatment, and a move to return to community care as quickly as possible. That is not a rehabilitation focus so it is different to the needs of patients who have ongoing, what we term chronic, severe symptoms and severe illness."*[38]

43. Dr Fryer said that development of more intensive services such as the Assertive Mobile Youth Outreach Service (AMYOS), along with education and residential facilities, may reduce or remove the need for sub-acute inpatient services.[39] However, when asked about this later, she agreed that Queensland does not have a full suite of services like this yet

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35 Exhibit 144, Submission from the Royal Australian & New Zealand College of Psychiatrists Statement [RAN.001.0001.0001].

36 Transcript, Michelle Fryer, 11 March 2016, p 25-11 lines 13–14.

37 Exhibit 144, Submission from the Royal Australian & New Zealand College of Psychiatrists Statement [RAN.001.0001.0001] [.0004].

38 Transcript, Michelle Fryer, 11 March 2016, p 25-13 lines 8–16.

39 Exhibit 144, Submission from the Royal Australian & New Zealand College of Psychiatrists Statement [RAN.001.0001.0001] at [.0004].

and acknowledged that the future is promising in the development of more services like AMYOS.[40]

44. The overall conclusion from Dr Fryer is:

> *"…the RANZCP supports consideration of a medium-term inpatient unit that provided extended treatment and rehabilitation. However, there are risks in models like these, such as; institutionalisation; diverting 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 [sic] and iatrogenic increase in disability."*[41]

<u>*Dr Graham Martin*</u>

45. Dr Martin's opinion on the desirability of extended treatment and rehabilitation of a similar cohort and environment as the BAC is as follows:

> *"I have always tried to manage young people in my care outside of an inpatient setting, if at all possible. Sometime this is neither reasonable nor possible. For example, if the patient threatens or actually attempts suicide, or their condition becomes so severe that it is unreasonable for them to stay in their home environment, or they become psychotic, then it is crucial to refer them to a hospital inpatient service, so that they can be treated temporarily in a place of containment and safety. This can sometimes mean that they are discharged back to my care on a number of medications that have to be carefully managed in the outpatient clinic environment prior to, or alongside, the resumption of the prior psychotherapeutic process."*[42]

46. However, it should be noted that his view on this issue is limited because he has not had contact with BAC patients since 2004/2005.[43]

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[40] Transcript, Michelle Fryer, 11 March 2016, p 25-18 lines 12–13.

[41] Exhibit 288, Supplementary Submission from the Royal Australian & New Zealand College of Psychiatrists [RAN.001.0002.0001] at [.0004].

[42] Exhibit 306, Supplementary affidavit of Graham Martin, 19 February 2016, para 3 [CHS.900.006.0001] at [0001]-[0002].

[43] Exhibit 306, Supplementary affidavit of Graham Martin, 19 February 2016, para 4 [CHS.900.006.0001] at [0002].

47. Dr Martin reiterated that: "At this point in time, I have not been able to find any sound evidence to support the programs replacing an inpatient unit that can manage these seriously troubled young people."[44]

48. Dr Martin believes there is a need for inpatient facilities in the Queensland Health care system, stating:

> *"There will always be damaged people and young people who need longer term care. Some of these will need inpatient care, protection from adverse family dynamics or abuse of one form or another, and the time necessary to get them to the point of reintegration to society. I believe we do need a facility or facilities that can provide longer-term inpatient care even if this is limited to the 6 months as I believe is recommended by the Faculty of Child and Adolescent Psychiatry of the Royal Australian and New Zealand College of Psychiatrists (RANZCP)... It may be that we need also to consider a number of other emerging semi-residential community programs to take pressure off the available inpatient beds (if such pressure is a reality)."*[45]

49. In relation to the proposition (put forward by Dr Stathis in oral evidence) that there is limited compelling evidence for extended inpatient admission, Dr Martin noted that there is actually very little quality evidence that supports many treatment programs (not just long term youth treatment facilities),[46] and that this lack of evidence could be due to the fact that there is no evaluation or outcomes process in place. In particular, he states:

> *"I have attempted to locate evidence-based research that supports long term youth treatment facilities. However, it is also true that there is little evidence-based outcome research that supports many other treatment programs".*[47]

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[44] Exhibit 306, Supplementary affidavit of Graham Martin, 19 February 2016, para 8 [CHS.900.006.0001] at [0003].

[45] Exhibit 306, Supplementary affidavit of Graham Martin, 19 February 2016, para 31 [CHS.900.006.0001] at [0014].

[46] Transcript, Graham Martin, 11 March 2016, p 25-32; Exhibit 306, Supplementary affidavit of Graham Martin, 19 February 2016, para 11 [CHS.900.006.0001] at [0004].

[47] Exhibit 306, Supplementary affidavit of Graham Martin, 19 February 2016, para 11 [CHS.900.006.0001] at [0004]

"We don't do that (evaluation or outcomes processes). We're not supported to do that. And strangely, when we are supported to do that, like in a service called Evolve, which actually was fairly rigorous, strange things happened".[48]

Dr Breakey

50. Dr Breakey makes his position clear, saying: "The adolescents admitted to the BAC tended in my view to have more severe and complex mental health conditions than those who could be successfully treated by community or acute services."[49]

51. On 22 November, Dr Breakey wrote a letter to Minister for Health Lawrence Springborg's Office Manager, Colleen Mille, outlining the major implications for closing the BAC. Interestingly, he said that "acute units by design cannot offer the range of activities and interventions necessary for these patients and do not have fully integrated schools."[50]

52. On 24 April 2013, Dr Breakey wrote a letter to Mr Springborg voicing his concerns about closing the BAC. He stated:

"It will surprise me if the expert panel can develop a safe model that doesn't include some long-term inpatient care for the relatively small number of extremely disturbed and distressed adolescents that BAC cares for. My 'evidence' for this is the constant referral to BAC of adolescents (unfortunately more than can be accommodated) for whom all other services have not been able to adequately help, and these agencies recognise the benefits of a period at BAC."[51]

53. Dr Breakey is an advocate for long-term inpatient care, suggesting "the model of long-term inpatient care coupled with an onsite school offered by BAC until its closure is the most effective model care for adolescents with at the severe end of mental health issues, who had already exhausted existing safe community options".[52] He does not agree with the criticism that the BAC adolescents were staying too long. For example, he said "this criticism focuses too much on the concept of institutionalisation and ignores

48 Transcript, Graham Martin, 11 March 2016, p 25-32 lines 15–20.
49 Exhibit 172, Supplementary statement of Cary Breakey, 25 January 2016, para 12 [WIT.900.021.0001] at [0003].
50 Exhibit 27, Statement of Cary Breakey, 28 August 2015 at Exhibit F [WIT.900.002.0001] at [0022].
51 Exhibit 27, Statement of Cary Breakey, 28 August 2015 at Exhibit G [WIT.900.002.0001] at [0024].
52 Exhibit 172, Supplementary statement of Cary Breakey, 25 January 2016, para 39 [WIT.900.021.0001] at [0007].

rehabilitation".[53] As a result, he advocated for "…several more centres such as the BAC situated in a number of locations including regional Queensland would in my view be preferable."[54]

54. He believes that AMYOS is not useful as a 'stop gap' for the BAC.[55] Furthermore, Headspace is not appropriate for most of the BAC cohort as the model is "complicated and often rigid" and provides a limited number of sessions,[56] and "many services have difficulty maintaining staff with sufficient skills, experience and emotional resilience".[57]

55. Dr Breakey criticised referral services for complaining about the length of stay causing a bed block, stating:

> *"The plan at the BAC was always to get adolescents back to their families and the communities in the shortest time possible, if BAC had been better supported with other services, this could have been achieved faster."*[58]

56. Dr Breakey also mentions that he attended a RANZCP meeting held on 27 November 2012 and the consensus was for the BAC service continuing in some form.[59]

57. Ultimately, Dr Breakey believes there is a significant gap in mental health services for adolescents in Queensland.[60] He believes the closure of the BAC is flawed for the following reasons and strongly supports an inpatient unit like the BAC:

    (a) There is no more contemporary model that is effective in treating this group of adolescents. By the time patients reached the BAC, almost all had recurrent failed admissions to acute units. These units did not have the capacity to care for the patients, and could not provide an opportunity for the patients to become

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53 Exhibit 27, Statement of Cary Breakey, 28 August 2015, para 22 [WIT.900.002.0001] at [0005].
54 Exhibit 27, Statement of Cary Breakey, 28 August 2015, para 40 [WIT.900.002.0001] at [0007].
55 Exhibit 172, Supplementary statement of Cary Breakey, 25 January 2016, para 33 [WIT.900.021.0001] at [0008].
56 Exhibit 172, Supplementary statement of Cary Breakey, 25 January 2016, para 35 [WIT.900.021.0001] at [0008].
57 Exhibit 172, Supplementary statement of Cary Breakey, 25 January 2016, para 36 [WIT.900.021.0001] at [0008].
58 Exhibit 172, Supplementary statement of Cary Breakey, 25 January 2016, para 27 [WIT.900.021.0001] at [0006].
59 Exhibit 172, Supplementary statement of Cary Breakey, 25 January 2016, para 28 [WIT.900.021.0001] at [0006]-[0007].
60 Exhibit 172, Supplementary statement of Cary Breakey, 25 January 2016, para 37 [WIT.900.021.0001] at [0008].

comfortable with staff in a two week period. And many of these patients were (or were seen) as disruptive to the management of other patients in these units;

(b) The risk of harm from forensic patients is not a valid concern. Security Patients were sited at Wolston Park, along with the BAC, since 1983 with far less monitoring capacity than today, with no threats or incidents arising;

(c) While the building has deteriorated, it could be refurbished relatively cheaply rather than relocating or closing the BAC;

(d) Average bed occupancy is an inappropriate measure of utility of this kind of facility, given the importance of reintegrating patients into the community as part of their treatment. When patients were on, for example, weekend leave as part of this process, this would be recorded as 'empty beds', despite the fact that BAC staff would still be fully responsible for their care and often acutely involved in counselling patients or parents over the phone, often visiting families, or facilitating return to the unit.[61]

[61] Exhibit 27, Statement of Cary Breakey, 28 August 2015, para 42 [WIT.900.002.0001] at [0007]-[0008].

<u>*Professor Kotzé*</u>

58. In oral evidence, Professor Kotzé does not rule out the possibility of inpatient stays as an option, suggesting that:

> *"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 day and inpatient care when it is not possible to provide the type or intensity of treatment or clinical risk management <u>in levels of specialist a less restrictive setting</u>. 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."*[62]

59. However, Professor Kotzé mentions that adolescents do not need to continue to stay in an inpatient facility if the necessary community support systems and transition arrangements are put in place:

> *"…They don't really need to remain in the inpatient setting and you're really putting in place something to bridge that gap and to enable them to leave hospital but also enable them to be better able to manage situations as they start to escalate without having to escalate to the point where it's inevitable they end up in the emergency department and being readmitted.*[63]
>
> *Day patient and community-based services are strongly evidence-based in child and adolescent mental health. Intensive day patient and assertive community care teams have been shown to reduce the requirement for inpatient care and reduce length of stay. Outreach and transition support services linked to inpatient units have been shown to reduce length of stay and readmission rates in child and adolescent mental health."*[64]

<u>*Dr Groves*</u>

62 Exhibit 71, Statement of Beth Kotzé, 18 December 2015, para 19 [PBK.900.001.0001] at [0005].
63 Transcript, Beth Kotzé, 9 March 2016, p 23-14 lines 23–27.
64 Exhibit 71, Statement of Beth Kotzé, 18 December 2015, para 20 [PBK.900.001.0001] at [0006].

60. Dr Groves, who has considerable experience in planning health services in Queensland, Western Australia and South Australia, said that:

> *"there seems to be a common group of people who are not well-served by acute units. They are no(t) well-served by community-based services. They are not well-served by wraparound however that's defined. And from time to time they come into contact with and will need a much more comprehensive package of services. Whether you call it subacute – and I know that the language has varied considerably."*[65]

61. Dr Groves advocated for a BAC type facility, for example:

> *"…there was a clear need for a service for the group of adolescents with severe longstanding mental health problems that had not done well within the acute CYMHS service system. This group was often but not exclusively, characterised by having high levels of distress, behavioural disturbance, backgrounds that often involved high levels of complex trauma or deprivation or neglect, together with the possibility that they had also been in institutional care or for long periods or had lived out of home. lt also consisted of a group who had been either non-responsive or only partially responsive to standard first line treatment approaches."*[66]

> *"There was also a concern that in the absence of such a service, if such young people spent extended time in acute units, this reduced the overall availability of acute inpatient units for young people who required more support than could be provided by even intensive community based child and youth teams."*[67]

62. For many in the BAC group there were very high levels of self-harming and suicidal behaviours that could not be safely managed in short term treatment programs.[68]

<u>*Dr Stathis*</u>

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65 Transcript, Aaron Groves, 16 February 2016, p 7-83 lines 13–18.
66 Exhibit 58, Statement of Aaron Groves, 21 January 2016, para 89 [GRA.020.001.0001] at [.0016].
67 Exhibit 58, Statement of Aaron Groves, 21 January 2016, para 90 [GRA.020.001.0001] at [.0016].
68 Exhibit 58, Statement of Aaron Groves, 21 January 2016, para 94 [GRA.020.001.0001] at [.0016].

63. Dr Stathis' written evidence was that there may be limited need for adolescent subacute beds if the whole of the continuum is endorsed and funded.[69]

64. However, perhaps because of his somewhat antagonistic attitude in the witness box, Dr Stathis was not willing to orally subscribe to that view.

65. In oral evidence, Dr Stathis described the subacute beds within the acute ward at the former Mater Children's Hospital ("the Mater"), and Lady Cilento Children's Hospital ("the LCCH") as a "suboptimal" option, which was not ideal.[70] Dr Stathis recounted being aware that the ECRG report addressed the question of treating subacute patients in an acute ward:

> "*I'm also aware that it was accepted with a caveat that we'd have to look at other models of service for tier 3 and that there was no other place to put these young people*".[71]

66. Dr Stathis' view that there may be limited need for adolescent subacute beds appears to be based on two propositions in his evidence. First, that the number of referrals to the subacute beds at the Mater and LCCH has been low and therefore, there is no demand for this type of service. For example, in oral evidence, Dr Stathis stated that:

> "*We also didn't know what the appetite for these beds were so we had to monitor that. And it was curious that although this memo from Sharon Kelly was sent out right across the State from 22 October, I received no requests for subacute beds.*
>
> *....I'm just simply saying I didn't receive any requests*".[72]

67. The second proposition is that there is limited compelling evidence for extended inpatient admission. In oral evidence, Dr Stathis commented as follows in relation to a suggestion in the Subacute Discussion Paper (authored by Sophie Morson) that there are three groups that may benefit from an extended inpatient admission – those with severe psychosis, those with a life threatening eating disorder and those who have not responded sufficiently to treatment in a less restrictive setting:

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[69] Exhibit 123, Supplementary statement of Stephen Stathis, 15 January 2016, para 45 [DSS.001.002.001].
[70] Transcript, Stephen Stathis, 10 March 2016, p 24-49 lines 1–40.
[71] Transcript, Stephen Stathis, 10 March 2016, p 24-49 lines 14–16.
[72] Transcript, Stephen Stathis, 10 March 2016, p 24-49 lines 19–27.

> *"<u>The point is may benefit</u> because there's very limited evidence. And after – and we actually said there was limited compelling evidence for a subacute unit except possibly in these three groups, which is, as you've read, severe psychosis – and it's a life-threatening eating disorder with coexisting medical complications".*[73]

68. However, during oral evidence, the Commissioner noted that there may be inconsistency in relation to these propositions:

> "*What I'm grappling with, Doctor, is this: you say you've had such a limited uptake for the subacute beds in an acute unit which seems to me to be different from the concept, for example, that was being worked up at – for Redlands, which was different from the Barrett Adolescent Centre in terms of the length of stay. There seems to me lots of criticism of the length of stay at the Barrett Adolescent Centre. Dr Sadler has given some explanations for it. I'm not entering into that at the moment. But a reduced length of stay and the other changes that Redlands would have made from how the Barrett was managed seems to me to be a different concept from subacute beds at an acute unit. And I'm – I just don't know that we're comparing apples with apples in the way you're speaking*".[74]

69. In response, Dr Stathis noted that:

> "*You could argue – it would be reasonable to argue that the limited referrals are because we have had to, because there is no capital build, put together these swing beds. We don't know. What we do know is that there are very few dedicated subacute units anywhere in the world. And from the discussions I've had, these are closing. They're not opening any new ones*".[75]

<u>*Dr Sadler*</u>

70. Dr Sadler clearly supports the BAC facility, stating in his written evidence:

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[73] Transcript, Stephen Stathis, 10 March 2016, p 24-54 lines 34–37.
[74] Transcript, Stephen Stathis, 10 March 2016, p 24-71 lines 26–35.
[75] Transcript, Stephen Stathis, 10 March 2016, p 24-71 lines 36–41.

"...for some adolescents, the benefit of receiving treatment at a centre with a model of care similar to BAC will be more beneficial than the community based care that may be available closer to home."[76]

71. In Dr Sadler's first supplementary statement to the Commission, he explained that not all adolescents will be suited to care in a community setting, stating:

"...adolescents with severe and persisting anxiety could not be successfully treated outside BAC is because their intense avoidance secondary to anxiety was difficult to overcome because of the intensity of interventions required. Most community settings to which they could be exposed caused a flooding of anxiety which they found intolerable."[77]

72. Dr Sadler is less supportive of acute and sub-acute units located in a hospitalised setting. This is seen in a number of statements, both in his written and oral evidence, for example:

"My experience with acute inpatient units is that there is a focus on discharging the adolescent as soon as possible. Stability of relationships and stability of environment are essential to the treatment of these adolescents. This stability cannot be found in sub-acute beds located at the Lady Cilento Children's Hospital as these beds are located within the acute inpatient unit and, as such, there would necessarily be a certain level of instability in the cohort of adolescents."[78]

"...there are several types of interventions that were available at BAC but are not available in the acute inpatient settings. The average length of stay in an adolescent acute inpatient unit is around 10 days. Those adolescents with severe and persisting anxiety, were rarely admitted to an acute inpatient unit, because of the length of time required for change. Day programs are much more appropriate, if they could access them, or BAC if they could not because they offered the level of intensity of interventions, in a stable community with a low stimulus environment which helped to prevent flooding with anxiety. Often available community settings

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[76] Exhibit 179, Supplementary affidavit of Trevor Sadler, 12 February 2016, para 177 [DTZ.900.002.0001] at [0042].

[77] Exhibit 179, Supplementary affidavit of Trevor Sadler, 12 February 2016, para 125 [DTZ.900.002.0001] at [0029].

[78] Exhibit 179, Supplementary affidavit of Trevor Sadler, 12 February 2016, para 175 [DTZ.900.002.0001] at [0042].

are too anxiety provoking, and do not allow for the same level of graded exposure from a very low level of stimulus".[79]

73. However, he was supportive of the BAC facility and the specialised services it offered BAC patients, stating:

> *"As a general statement, BAC accommodated those adolescents who do not easily fit within the services provided by other models. BAC allowed adolescents to seek treatment within a stable cohort of adolescents and I believe that continuity of care, coupled with a stable cohort of adolescents is lacking in the AMHETI."*[80]

Professor McDermott

74. When Ms Wilson QC put the suite of services question to Professor McDermott, he warned that those services would need to exist and might not continue to exist:

> *"Now, we haven't established that that's happened, to my knowledge. It might be happening and that would be magnificent. But sometimes what you'd find is that you'd find that the care is, in fact, disintegrated and a different cohort go to here and a different cohort go to there. In which case, it will not replace the comprehensiveness that it's meant to."*[81]

75. In Professor McDermott's statement, he believed it was appropriate to develop a similar facility as the BAC with updated program elements:

> *"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."*[82]

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[79] Exhibit 179, Supplementary affidavit of Trevor Sadler, 12 February 2016, para 150 [DTZ.900.002.0001].
[80] Exhibit 179, Supplementary affidavit of Trevor Sadler, 12 February 2016, para 177 [DTZ.900.002.0001] at [0042].
[81] Transcript, Brett McDermott, 16 February 2016, p 7-54 lines 40–44.
[82] Exhibit 84, Statement of Brett McDermott, 10 November 2015, para 164 [PBM.001.002.001] at [.029].

Expertise Underpinning the QPMH

76. Two other points need to be made about expertise on this fundamental issue. The first point is that a number of witnesses accepted that the original decision to replace the BAC, made as part of the process of putting together the Queensland Plan for Mental Health 2007-2017 (QPMH), was itself underpinned by specialist, expert advice.

77. In the first instance that evidence comes from Dr Aaron Groves, who is widely accepted as the architect of the QPMH. Dr Groves gave evidence that in 2006 he was asked by the then Director-General of Queensland Health to prepare a plan for mental health. It was expected that the plan would be finished in 2006. As there was only a short period of time within which to develop the plan, Dr Groves established a number of expert groups and charged them with the responsibility of looking at mental health from a planning perspective through the prism that was most relevant to their area of expertise.

78. Dr Groves' evidence is that the Child and Youth Network looked at child and adolescent issues and, with the assistance of staff from Queensland Health, put forward a report that made recommendations about the important planning elements that should be considered in the QPMH. What followed was a serious process of costing, after which the plan was submitted to cabinet for consideration as to whether cabinet would fund those elements.

79. Dr Leanne Geppert's evidence was that the QPMH was a part of the process of reform:

> *"… 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 occurred through the plan."*[83]

80. Ms Kelly was asked whether she knew or had assumed that the decision to relocate the BAC to another site was supported by expert advice. Her answer was simply: "I would

83 Transcript, Leanne Geppert, 19 February 2016, p 10-7 lines 35–42.

imagine that anything in the plan was supported by expert advice, so, yes, I was aware of that."[84]

81. Former Director-General for Queensland Health, Dr O'Connell, accepted the proposition that, while he was not employed by Queensland Health at the time that the QPMH was formulated, he assumed that its contents were informed by expert advice.[85] He based that assumption on his knowledge that, generally speaking, plans which are of that level of importance are circulated to expert clinicians before they are finalised. This is substantiated by Dr Kingswell who agreed that the QPMH was compiled with expert input for each of its component parts.[86]

The ECRG's Report

82. The second point is that the ECRG were unequivocal in their views that a tier 3 facility (that is, a design-specific and clinically staffed bed-based service) was essential. The ECRG was a group with considerable expertise and community representation. The membership of the ECRG is explained in the following table:

Name	***Position / Expertise***	***Org location***	***Notes***
Dr Leanne Geppert (Chair)	Director, Planning and Partnerships Unit, Mental Health, Alcohol and Other Drugs Branch	MHAODB	Nominated as chair by Chris Thorburn, Acting Director Services Redesign, WMHHS on 23/11/12.[87]

84 Transcript, Sharon Kelly, 22 February 2016, p 11-7 lines 24–26.
85 Transcript, Anthony O'Connell, 23 February 2016, p 12-20 lines 24–29.
86 Transcript, William Kingswell, 24 February 2016, p 13-18 lines 28–36.
87 Exhibit 55, Statement of Leanne Geppert, 16 October 2015, para 5.6 [WMS.9000.0004.00001]; Dr Geppert noted the role of the chair was "to be an enabler for the members of the ECRG to consider and debate issues and to reach a consensus opinion which could be placed into a report that would be considered by the Planning Group of WMHHS": Exhibit 55, Statement of Leanne Geppert, 16 October 2015, para 5.1 [WMS.9000.0004.00001].

Name	*Position / Expertise*	*Org location*	*Notes*
	Consumer representative	CREATE Foundation	• Joined at Meeting 4 on 27 February 2013. • Former BAC patient and now Community Facilitator in the Queensland office, CREATE Foundation — national peak consumer body representing the voices of children and young people with an out-of-home care experience (including kinship care, foster care and residential care).
Ms Amelia Callaghan	Headspace State Manager, Queensland, NT & WA	Headspace	Headspace is a national organisation with nearly 100 offices serving young people aged 12-25[88]
Dr Michele Fryer	Queensland Faculty of Child and Adolescent Psychiatry (QFCAP), Royal Australian and New Zealand College of Psychiatrists (RANZCP)	QFCAP (also QHealth)	Child and Adolescent Psychiatrist
Ms Emma Hart	Nurse Unit Manager, Adolescent Inpatient Unit and Day Service, Townsville HHS	Townsville HHS	Nursing Representative
Dr David Hartman	Clinical Director, Community Youth Mental Health Service	Townsville HHS	Child and Adolescent Psychiatrist

88 Exhibit 32, Affidavit of Amelia Callaghan, 14 January 2016, para 3(d) [HSP.900.0001.0001].

Name	*Position / Expertise*	*Org location*	*Notes*
Professor Philip Hazell	Director, CAMHS, Sydney Local Health District Director, Thomas Walker Hospital (Rivendell), CAMHS	Interstate FCAP representative (NSW)	Child and Adolescent Psychiatrist. Nominated by QFCAP.[89]
Mr Kevin Rodgers	Principal, Barrett School	DETE	Principal of the integrated school
Dr Trevor Sadler	Barrett Adolescent Centre	WM HHS	Child and Adolescent Psychiatrist. Dr Carey Breakey attended the first meeting (on 7/12/12) as Dr Sadler's proxy
Dr James Scott	Consultant Psychiatrist Early Psychosis	MN HHS	Child and Adolescent Psychiatrist. Nominated by QFCAP
Ms Josie Sorban	Director of Psychology, CYMHS	CHQ HHS	Psychologist. Allied health representative
Ms Amanda Tilse	Operational Manager, Alcohol, Other Drugs and Campus Mental Health Services, Mater Children's Hospital	Mater Hospital	Nursing representative
CONFIDENTIAL	Carer representative		• Joined at Meeting 4 on 27 February 2013. • Minutes from the 13 February meeting note that Chair and Secretariat were responsible for briefing the consumer and carer representatives

89 Exhibit 63, Affidavit of Philip Hazell dated 5 November 2015, paras 65-66 [WIT.900.005.0001].

Name	*Position / Expertise*	*Org location*	*Notes*
	Not a member of the ECRG, but nominated to provide support and debriefing to the consumer and carer representatives	Mater Hospital	was a Consumer Consultant at Mater Child and Youth Mental Health Service.

83. As can be seen, the ECRG included community and carer representatives as well as a number of psychiatrists with specialist expertise in the area of adolescent mental health. Dr Fryer, Dr Hazell, Dr Hartman, Dr Sadler and Dr Scott had specific clinical expertise in that field.

84. The preamble to the ECRG report acknowledged the challenges (such as a lack of funding) and the current policy (that non acute bed-based services should be community-based wherever possible) but was unequivocal that a design-specific and clinically staffed bed-based service is essential for adolescents who require medium-term extended care and rehabilitation:

> *"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 culture sensitivity, with the minimum possible disruption to family, educations, social and community networks. The ECRG comprised of consumer and carer representatives, and distinguished child and youth mental health clinicians across Queensland and New South Wales who were nominated by their peers as leaders in the field. The ECRG would like to acknowledge and draw attention to the input of the consumers and carer*

representatives. They highlighted the essential role that a service such as BAC plays in recovery and rehabilitation, and the staff skill and expertise that is inherent to this particular service type. While there was also validation of other CYMHS service types, including community mental health clinics, day programs and acute inpatient units, it was strongly articulated that these other service types are not as effective in providing safe, medium-term extended care and rehabilitation to the target group focused on here. It is understood that the BAC cannot continue it its current form at TPCMH. However, ***it is the view of the ECRG that*** *like that 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 available currently in both Queensland and New South Wales (e.g., the Walker Unit). The service model elements document (attached) has been proposed by the ECRG as a way forward for adolescent extended treatment and rehabilitation services in Queensland* [our emphasis added].*"*[90]

85. The ECRG's second key message is important for present purposes. The ECRG was alert to the argument that the BAC cohort could be properly cared for by a combination of day program care, residential community based care and acute inpatient/hospital facilities. The ECRG rejected that argument. Under the sub-heading: "2. Inpatient extended treatment and rehabilitation care (Tier 3) is an essential service component" is the following explanation:

"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)* [our emphasis added].

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90 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 865 [WMS.9000.0006.00001] at [.00865].

- *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, therapies 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 for acute treatment."*[91]

86. The ECRG's second recommendation was, therefore, as follows:

"A Tier 3 service should be prioritised to provide extended treatment and rehabilitation for adolescents with severe and persistent mental illness."[92]

87. The ECRG's third key message identified risk if a Tier 3 facility was not available. The sub-heading was: "3. Interim service provision if BAC closes and Tier 3 is not available is associated with risk". The text was as follows:

- *"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 specific specialist staff skills and expertise in the area of adolescent extended care in Queensland if BAC*

[91] Exhibit 66, Statement of Sharon Kelly, 16 October 2015, pp 865–866 [WMS.9000.0006.00001] at [.00865]-[.00866].
[92] Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 866 [WMS.9000.0006.00001] at [.00866].

closes and a Tier 3 is not established in a timely manner. This includes both clinical staff and education staff.[93]

88. Therefore, the ECRG's third recommendations were as follows:

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."[94]

Safety Net?

89. There is another, perhaps collateral, aspect of the BAC/Redlands model that deserves to be mentioned.

90. Some patients at the BAC did not easily fit into any other health service.

91.

92. As Dr Groves said, there are a group of young people who are not well service by other services.

[93] Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 866 [WMS.9000.0006.00001] at [.00866].
[94] Exhibit 66, Statement of Sharon Kelly, 16 October 2015, p 866 [WMS.9000.0006.00001] at [.00866].

Conclusions

93. It follows that the specialist expert advice, including those who designed the Queensland Plan for Mental Health 2007-2017 and the members of the ECRG, all accepted that a design-specific and clinically staffed bed-based service is essential for adolescents who require medium-term extended care and rehabilitation.

94. It can be seen from the quotation from the ECRG's preamble set out above that the ECRG were conscious of the policy that non acute bed-based services should be community-based wherever possible.[95] However, they were nevertheless convinced that a Tier 3 facility is essential as there is a small group of young people whose needs cannot be safely and effectively met through alternative service types.

95 The ECRG attributed that policy to the *National Mental Health Policy (2008)*.

PART C: THE SECOND ISSUE – SUB-ACUTE BEDS IN AN ACUTE UNIT

95. The second real issue, and it is an issue related to the fundamental issue considered above, is this; can the vulnerable young people with severe, persistent mental illness be accommodated in a facility such as Lady Cilento's Acute Adolescent Mental Health unit?

96. Again, this is an issue informed by the expert evidence.

Expert Evidence

97. First, Dr Scott explained that:

> "*The difficulty of subacute beds – I was at the Lady Cilento Hospital a couple of weeks ago, looking at the unit there, and it's certainly not somewhere where I would want a young person housed for any length of time. It's up on a high level. The outdoor areas are small courtyards. There's no cover from the sun. There's a gym with an exercise bike sitting in the corner that looks like it hasn't been used since it's been placed there. I think that it would be an* ***unhealthy environment*** *for any young person to be there for any length of time.*"[96] [Our emphasis added].

98. Second, Dr Groves gave evidence that, by their very nature, the sub-acute beds at the Lady Cilento Hospital are in a more "medicalised environment" than residential facilities. He said:

> "*I mean, even mental health units which are less medical than say, for example, an acute paediatric unit or an acute surgical unit, they – they are still medical by their very nature. They are hospital beds. They need to reach a whole lot of hospital standards. Those standards are very different from what you try and provide in a residential facility however you form it.*"[97]

99. Dr Groves commented specifically on the facility at the Lady Cilento Hospital in this way:

> *"The facility? I think the facility has a very good – infrastructure is very modern inpatient unit. I think it's quite impressive particularly compared with other child acute units throughout the country. My understanding from talking to staff is that*

[96] Transcript, James Scott, 17 February 2016, p 8-13 lines 11–18.
[97] Transcript, Aaron Groves, 16 February 2016, p 7-85 lines 5–18.

there are some current difficulties in the length of stay and flow through the unit because some people have a length of stay that is longer – or exceeds what's expected and that the number of sub-acute beds isn't sufficient for all of the people for that unit. That's what I was told at the time. I have nothing further to add than that. I think I might make the comment, though, it was really designed primarily to be an acute unit on both sides – the youth side and the child side. I think that Professor McDermott talked about the difficulties of providing a good range of care in a more homelike environment in an acute unit. I think that whilst the Lady Cilento Hospital's service is clearly modern and much better designed than – than many others it doesn't mitigate all of those issues. But it's certainly a lot better than might otherwise have been the case."[98]

100. Third, Professor McDermott's evidence, referred to by Dr Groves, was as follows:

"*… I think acute wards are very, very unusual places. They are places where, you know, your bedroom is different, your kitchen is different, your bathroom is different, you're living with different people. Your nurses change shift every eight hours or 10 hours. There's a range of professionals that come and go. It's very highly-ordered, but unusual to the, kind of, normal ecology of a family. Not only that, individuals come in, sometimes daily, who are highly distressed, who might have cut themselves off and, really, in a very, kind of, a – you know, damaging and profound way. They might have taken a major overdose. There's a – they might have been distressed because of recent notification of sexual or physical abuse. But they are places which are often not settled, often there is noise, often there is violence. There is quite a lot of literature about staff, for instance, being assaulted on acute inpatient wards.* ***These are places that I don't think are places for rehabilitation and we want to step down someone to a home-like environment****. So, generally speaking, I think that inpatient ward hospital base for great acuity, stepping down into highly-scaffolded but, you know, quite home-like environment as the second step, and I would encourage the Commissioner – I'm allowed to speak to you directly – there is a – there is a five-bed residential unit called Adores. It's a drug and alcohol residential unit for – in Clarence Street in Woolloongabba, and it has a wonderful, home-like environment for five adolescents, within reach*

98 Transcript, Aaron Groves, 16 February 2016, p 7-84 line 35 – p 7-85 line 2.

of mental health professionals. So it is possible to have this step-down, home-like experience that's an intermediate between home and inpatient unit.

…

You can try to make the experiences more and more and more homelike and the more you achieve that the less my concerns but at the end of the day you will always be in a large hospital and all that goes with that. But at the end of the day you still come and go on leave to a hospital. You go past ambulances and all this kind of thing so – but if you can achieve a homelike environment then my concerns are somewhat assuaged."[99] [Our emphasis added].

101. Fourth, Dr Breakey gave evidence of his concerns about the suitability of sub-acute beds in an acute ward. He said:

"*The particular cohort of kids that we consistently had at Barrett are ones who are generally seen as not coping well with the acute units because of the – the regular changeover of kids and the – these – many of the Barrett cohort have attachment issues and anxieties and learning – coping with new kids at every step is a big problem for them, as is coping with changes in staff. So acute units generally see the Barrett cohort of patients as not – not settling in well or even being disruptive in the acute services*."[100]

102. Fifth, Dr Ward gave evidence about his research. He said:

"*One of the things that came out in my research is that particularly for extended stays, the adolescents see that facility as essentially a home away from home. If we are to get the adolescents back on track developmentally, then the physical surrounds – the physical environment has to take that into consideration. For example, activities that are developmentally appropriate; own bedrooms; private space; all the typical and normative aspects of an adolescent's life should be, as much as possible, reflected in that hospital environment*."[101]

99 Transcript, Aaron Groves, 16 February 2016, p 7-43 line 41 – p 7-44 line 29.
100 Transcript, Cary Breakey, 15 February 2016, p 6-53 lines 24–30.
101 Transcript, David Ward, 15 February 2016, p 6-58 lines 24–29.

103. Sixth, Dr Hazell gave powerful evidence about the challenges of accommodating sub-acute patients in an acute unit:

> "*The experience that I've had in developing and working with an acute unit in Newcastle before I moved to Sydney was that there were major challenges in managing the more severe and persistently unwell young people in the acute ward environment. The challenges were, first of all, resource allocation. So inevitably acutely unwell, recently arrived patients tend to soak up most of the clinician time and attention. It's a reality. It's unavoidable, because you need to quickly assess a situation and try and resolve the immediate distress. So the first problem is an issue of resource allocation. The second issue is a problem with milieu. So with our severe and persistently unwell patients, we're trying as hard as we can to get them to a stable state where there's not too much fluctuation in their emotional regulation and their behaviour, but because of the nature of their illnesses they're still quite vulnerable and brittle. The experience in an acute unit is that every time you introduce a new acutely unwell patient you destabilise the longer-term patients. So that is going to be the risk of running a subacute service within the confines of an acute unit. Some of those concerns can be mitigated by ensuring that there are adequate resources, but it's not going to alter the milieu issue*."[102]

104. Seventh, even Dr O'Connell, without any particular expertise in the field, acknowledged the difficulty of accommodating sub-acute patients in acute units. He gave evidence that:

> "*Clearly, beds to support these kind of troubled adolescents should be pretty special beds, you know, in the sense of isolated from the run-of-mill beds, appropriately supported by the right nurse to patient ratios, and with more of a home-like setting if they're going to be spending months on end there. So yes, anything which suggests that the beds are, really, just a slight variant from an ordinary acute bed would be of concern to me. Yes*."[103]

105. Eighth,

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102 Transcript, Philip Hazell, 17 February 2016, p 8-37 line 34 – page 8-38 line 3.

103 Transcript, Anthony O'Connell, 23 February 2016, p 12 -24 lines 11–16.

104 Transcript, Anne Brennan, 4 March 2016, p 20-79 lines 35–45.

106. Ninth, Dr Parry, the Medical Director[106] responsible for the adolescent mental health inpatient unit at the Lady Cilento Hospital, explained that:

(a) only ub-acute patients have used the 'swing' beds at Lady Cilento;[107]

(b) the 'swing' beds are frequently used by acute patients and it is not uncommon for all 11 beds to be occupied;[108]

(c) adolescents with chronic suicidal, challenging or aggressive behaviours related to problems of personality development and complex developmental trauma can regress in an inpatient setting and can adversely affect other patients in the inpatient unit, with the result that "*the combination of this group of extended treatment patients with acute patients together on an inpatient unit is likely to be deleterious to both groups*";[109]

(d) "*I worked for five years in a child and adolescent mental health inpatient unit in Adelaide where we ended up with a number of long term patients from the group with personality problems because of lack of accommodation at that time for them in the community. This led to dramatic worsening of their emotional and behavioural problems with a deleterious effect on the inpatient milieu and other patients on the unit*";[110]

(e) "*In 2000 I visited a number of adolescent mental health inpatient units whilst on a study trip to the United Kingdom. It was widely accepted practice to avoid having patients with chronic personality problems and self-harming behaviour on inpatient units with acute patients, apart from brief crisis admissions*."[111]

107. Tenth, Dr Fryer was keen to emphasize the different needs of the two groups of patients:

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105 Transcript, Anne Brennan, 4 March 2016, p 20-61 line 25 – p 20-62 line 13.

106 Dr Parry is the Medical Director, CYMHS Campus Services within the Lady Cilento Children's Hospital which is responsible for the adolescent mental health inpatient unit at Lady Cilento Hospital.

107 Exhibit 176, Statement of Peter Parry, 4 February 2016 [QHD.900.010.0001].

108 Exhibit 176, Statement of Peter Parry, 4 February 2016 [QHD.900.010.0001].

109 Exhibit 176, Statement of Peter Parry, 4 February 2016, para 21 [QHD.900.010.0001] at [.0007].

110 Exhibit 176, Statement of Peter Parry, 4 February 2016, para 22 [QHD.900.010.0001] at [.0007].

111 Exhibit 176, Statement of Peter Parry, 4 February 2016, para 22 [QHD.900.010.0001] at [.0007].

"*What do you say to the proposition that patients of the Barrett cohort, they are very severe patients requiring long or medium term inpatient service. What do you say to the proposition that those patients being treated in an acute unit? As the Commission has heard, those – the needs of those patients are different to acutely unwell patients where there's very much a focus on stabilisation of mental state, institution of often but not always medication and the correct treatment, and a move to return to community care as quickly as possible. That is not a rehabilitation focus so it is different to the needs of patients who have ongoing, what we term chronic, severe symptoms and severe illness*."[112]

108. Eleventh, Dr Breakey voiced his concerns about the location of sub-acute beds in an acute ward at the Lady Cilento Hospital. He explained that the particular adolescents at the BAC generally do not cope well with acute units because of the regular changes in patients and staff members combined with their issues of anxiety and learning.[113]

109. Twelfth, the only expert who was possibly in favour of the concept of treating sub-acute patients in an acute ward was Dr Kotzé. Dr Kotzé initially gave guarded approval to the concept:

"*And in your opinion is it appropriate for acute adolescent inpatients to be confined with extended treatment adolescent mental health inpatients in the same ward or unit? It really depends on the profile of clinical care need of the young person. It is certainly possible to do that and it is desirable in certain circumstances. It does have to be purposefully managed with good operational policies and good clinical leadership to ensure that the clinical care needs of both groups are met in parallel but it's certainly possible and certainly appropriate under certain circumstances.*

Okay? So for example, you might not necessarily want to transfer somebody out for the – for the last stage of a – an admission when they have established relationships, when there's an established and positive treatment trajectory in train and it might actually cause some disruption to send them to another setting where

112 Transcript, Michelle Fryer, 11 March 2016, p 25-13 lines 8–16.
113 Transcript, Cary Breakey, 15 February 2016, p 6-39 lines 41–45.

they've got to start again, essentially, in terms of establishing therapeutic relationships, for example."[114]

110. However, when the ECRG report was put to Dr Kotzé, she agreed with the ECRG:

"... Managing these young people in acute inpatient units does not meet their clinical, therapeutic or rehabilitation needs.

Do I take it that you then disagree with what the expert clinical reference group say here? Not at all. It's a spectrum within – within a category and they're – they're referring to another part of the spectrum."[115]

111. Lastly, Dr Stathis' evidence was that subacute beds in an acute unit was "suboptimal" and "not ideal":

*"Did you discuss with any expert, any child and adolescent expert who knew about this cohort, the idea of putting subacute beds in an acute ward? **We had no other option**. **And it was suboptimal.** But I did. On 26 November 2013 I presented the whole suite of services to the quarterly meeting of the faculty of child and adolescent psychiatrists, the most senior child and adolescent psychiatrists within the State. And I outlined the suite of services that were available, including beds within the Mater. Now, I knew that Brett was not going to be able to make that meeting. I can't recall why. But what I do recall very clearly is having a conversation with Brett before that meeting asking him whether he would mind if I mentioned the Mater. And he said he didn't mind at all. So I discussed this with some of the most senior child and adolescent psychiatrists in the State.*

You're aware, aren't you, that the ECRG report addresses this question of treating subacute patients in an acute ward? I'm aware of that. I'm also aware that it was accepted with a caveat that we'd have to look at other models of service for tier 3 and that there was no other place to put these young people.

Alright? We had no capital funds. And, in addition, we had only a few months before the Barrett closed to find possible beds. We also didn't know what the appetite for these beds were so we had to monitor that. And it was curious that

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114 Transcript, Beth Kotzé, 9 March 2016, p 23-9 line 39 – page 23-10 line 6.
115 Transcript, Beth Kotzé, 9 March 2016, p 23-10 lines 18–23.

*although this memo from Sharon Kelly was sent out right across the State from 22 October, **I received no requests for subacute beds**.*

Dr Stathis, do you conclude from that the fact that you received no requests for these subacute beds in acute wards, you conclude from that that there was no demand for it? I'm not concluding anything. I'm just simply saying I didn't receive any requests.

Have you spoken to Dr Peter Parry about this concept of having subacute beds in an acute ward? Peter Parry works under me as the medical director campus. Absolutely.

*And has he given you the benefit of his views about subacute beds in an acute ward? **All our view is that subacute beds in acute wards are not ideal**. But if there's no capital funding to build another unit and if there is no demand for another – for subacute beds, then I guess we have to make decisions about how to manage these young people.*[116] [Our emphasis added].

112. Apart from Dr Kotzé and Dr Stathis, the experts are unimpressed by the concept of mixing sub-acute and acute patients.

113. Most compelling are the views of Dr Scott and Dr Hazell, set out above, as well as the views of Dr Parry that: "*the combination of this group of extended treatment patients with acute patients together on an inpatient unit is likely to be deleterious to both groups*".[117]

114. In so far as Dr Kotzé and Dr Stathis are in dissent, their dissent is rather mild. Dr Kotzé agreed with the ECRG about the issue (see the discussion below). Dr Stathis said he had no other option and the solution was less than ideal. He seemed to take some comfort from the fact that there had been little demand for the sub-acute/swing beds. However, given the expert views regarding the likelihood of deleterious effects on both cohorts, it is difficult to imagine any child and adolescent psychiatrist referring a sub-acute patient to the acute ward.

116 Transcript, Stephen Stathis, 10 March 2016, p 24-49 lines 1–37.
117 Exhibit 176, Statement of Peter Parry, 4 February 2016 [QHD.900.010.0001].

ECRG Report

115. The ECRG report also addressed this issue:

- *"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."*[118]

Conclusions

116. Thus, the preponderance of the evidence is strongly against the concept of these young people being properly treated in acute units and, in fact, there are risks to the acute inpatients in attempting to mix the two cohorts.

Next Steps

117. So, how and why did we arrive at the point where there is no extended treatment facility available to the vulnerable young people who, before January 2014, would have been treated by the BAC?

118. The first step is to consider the legal basis for the decision to close the BAC, including the decision to cease the Redlands project. And then it is necessary to examine, as a matter of fact, the decision-making process.

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[118] Exhibit 66, Statement of Sharon Kelly, 16 October 2015 [WMS.9000.0006.00001].

PART D: THE LEGISLATIVE & POLICY CONTEXT

119. The legal basis for the decision to close the BAC, being a statewide facility operated and run by a single Hospital and Health Service (HHS), is not a straight-forward matter.

120. Confusion as to who had lawful authority to close a statewide facility and, equally, who purported to do so in respect of the BAC, is apparent on the evidence before the Commission. No person or entity undertook or accepted responsibility for the decisions which led up to the closure of the BAC. And so, not surprisingly, the decision was made in a fragmented way, with no proper analysis, and for disparate reasons based on unsafe factual foundations.

121. Unfortunately, to understand the legal basis for any decision to close the BAC, it is necessary to explain, in a little detail, the scheme of the *Hospital and Health Boards Act 2011* (the Act).

Framework of the public sector health system post 1 July 2012

122. With the commencement of the Act on 1 July 2012,[119] the 17 Health Service Districts throughout the state became statutory bodies and were renamed as HHS.

123. From that date, each HHS has operated independently, controlled by a local Hospital and Health Board (HHB)[120] and accountable through the HHB Chair to the Director-General[121] and Health Minister.[122] Each HHB is constituted as a body corporate[123] and:

> *'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.*'[124]

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119 As at 11 June 2015, incorporating amendments up to Act No. 7 of 2015.
120 *Hospital and Health Boards Act 2011*, s 7.
121 *Hospital and Health Boards Act 2011*, s 9.
122 *Hospital and Health Boards Act 2011*, Division 2.
123 *Hospital and Health Boards Act 2011,* s 18.
124 *Hospital and Health Boards Act 2011,* s 7(4).

124. However, even after 1 July 2012, the overall management of the public sector health system remained the responsibility of the Department of Health (the Department) through its chief executive.[125]

125. In the language of the Act, the Department's chief executive became known as the "system manager".

Role of the System Manager

126. Section 45 of the Act sets out the functions of the system manager, which include "to develop Statewide health service plans, workforce plans and capital works plans".[126]

127. The system manager has overall responsibility for management of the public health system, through the Director-General, subject to direction from the Minister (however in some instances may delegate functions under the Act to a HHS chief executive or an appropriately qualified employee of the Department).[127]

128. Sections 5 and 8 of the Act specify that when performing the system manager role, the chief executive is responsible for:

a. Statewide planning;

b. managing Statewide industrial relations;

c. managing major capital works;

d. monitoring Service performance; and

e. issuing binding health service directives to Services.[128]

129. Section 8(4) of the Act provides that, "The way in which the chief executive's responsibilities are exercised establishes the relationship between the chief executive and the Services."

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125 *Hospital and Health Boards Act 2011,* s 8(2).
126 *Hospital and Health Boards Act 2011,* s 45(c).
127 *Hospital and Health Boards Act 2011,* ss 44F and s 46(1).
128 *Hospital and Health Boards Act 2011,* s 8(3).

130. The object of the Act, being to deliver high quality hospital and other health services,[129] is to be achieved through factors that include the provision "for Statewide health system management including health system planning, coordination and standard setting".[130]

131. When performing a function or exercising a power under the Act, persons are required to have regard to guiding principles set out under section 13 of the Act, which are intended to guide the achievement of the Act's object:[131]

a. the best interests of users of public sector health services should be the main consideration in all decisions and actions under this Act;

b. there should be a commitment to ensuring quality and safety in the delivery of public sector health services;

c. providers of public sector health services should work with providers of private sector health services to achieve co-ordinated, integrated health service delivery across both sectors;

d. there should be responsiveness to the needs of users of public sector health services about the delivery of public sector health services;

e. information about the delivery of public sector health services should be provided to the community in an open and transparent way;

f. ...

g. ...

h. there should be engagement with clinicians, consumers, community members and local primary healthcare organisations in planning, developing and delivering public sector health services ...

129 *Hospital and Health Boards Act 2011,* s 5(1).
130 *Hospital and Health Boards Act 2011,* s 5(2).
131 *Hospital and Health Boards Act 2011,* s 13(2).

Responsibilities of a HHS

132. A HHS's main function is to deliver the hospital services and other health services stated in its particular service agreement.[132]

133. Service agreements are entered into between the chief executive of the Department (that is, the system manager) and the Chair of the Board of the relevant HHS. Service agreements are binding on each of them.[133]

134. Section 8(5) of the Act identifies the service agreement with each HHS as governing the relationship between the chief executive of the Department and a HHS.

135. Broadly, HHS's are responsible under their service agreements for matters such as:

    (a) *providing the facilities and services outlined in a schedule to the service agreement;*

    (b) *maintaining building and infrastructure; and*

    (c) *undertaking self-assessments.*[134]

136. HHS's are required to comply with the health service directives that apply to that HHS.[135] There are also provisions under the Act for performance reporting and health service auditing.[136]

137. Section 19 of the Act requires that HHS's:

    a. ***contribute to, and implement, statewide service plans that apply to the Service and undertake further service planning that aligns with the statewide plans;***[137]

    b. *undertake minor capital works, and major capital works approved by the chief executive, in the health service area;*[138]

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132 *Hospital and Health Boards Act 2011,* s 19(1).
133 *Hospital and Health Boards Act 2011,* s 35(3).
134 For example, see Exhibit 182, West Moreton HHS Service Agreement 2013/14 – 2015/16, HHS accountabilities of WMHHS at page 12 of its service agreement.
135 *Hospital and Health Boards Act 2011,* s 50.
136 *Hospital and Health Boards Act 2011,* Part 4.
137 *Hospital and Health Boards Act 2011,* s 19(2)(d).
138 *Hospital and Health Boards Act 2011,* s 19(2)(g).

c. ***maintain land, buildings and other assets owned by the Service;***[139]

d. *for a prescribed Service, employ staff under this Act;*[140]

e. ***cooperate with*** *other providers of health services, including other Services,* ***the department*** *and providers of primary healthcare,* ***in planning for, and delivering, health services.***[141] [Our emphasis added].

138. Interestingly for present purposes, section 20A of the Act, introduced by amendments which commenced on 1 July 2012, provides that a HHS could not buy or sell land, or grant or take certain leases of land or buildings, without prior approval of the Minister and the Treasurer.

Amendment of a Service Agreement

139. Section 39 of the Act requires that, if the chief executive (systems manager) or the HHS want to amend the terms of a service agreement, the party wishing to amend the agreement must give written notice of the proposed amendment to the other party. Amendment proposals are negotiated and finalised during set periods of time during the year, known as “amendment windows”.

140. Ultimately, negotiation and resolution of an amendment proposal is through a tiered process which culminates, if required, with a decision of the Minister for Health. Notwithstanding the existence of one or more disputes, the HHS must continue to perform and comply with the service agreement.

141. If the system manager considers an amendment may or will have associated impacts on other HHS’s or considers it appropriate for any other reasons, then it may propose further amendments and exercise statutory powers and/or directions under the Act.

142. Only upon execution of a deed of amendment by both the chief executive and the HHB Chair will the amendments documented by that deed be deemed to be an amendment to the service agreement.

139 *Hospital and Health Boards Act 2011,* s 19(2)(h).
140 *Hospital and Health Boards Act 2011,* s 19(2)(ha).
141 *Hospital and Health Boards Act 2011,* s 19(2)(i).

Funding to HHSs

143. Funding allocations to each HHS is centrally controlled by the system manager.

144. A "State pool account" is established by section 53B of the Act; a provision introduced by amendments to the Act which commenced on 2 August 2012. Payments into that fund include State and Commonwealth funds.[142]

145. Payments from the State pool account, including the timing of the payments, are made by the administrator at the direction of the Minister.[143]

146. Similarly, the Act establishes a "State managed fund".[144] Payments into that fund include block payments allocated by the state, or payments from the State pool account, for the provision of hospital and other health services under the National Health Reform Agreement.[145] Payments from the fund comprise payments to a HHS or to universities and other providers of teaching, training and research related to the provision of health services.[146] Payments are made by the chief executive.

Summary of Department and HHS roles

147. The Act governs the overall delivery of publicly funded health services within Queensland, detailing the key responsibilities and functions for the Department (or system manager) as well as each HHS (including its board and health service chief executive).

148. Under the Act, the primary responsibility of the system manager is the leadership and direction of Queensland's health system, which includes overseeing the HHS's at a statewide level.[147]

149. The Department funds each HHS by a "purchase" of the HHS's services under a service agreement, that is, an agreement between the chief executive of the Department and the particular HHS. Each HHS, in turn, is responsible for the delivery of health services in accordance with its service agreement with the Department's chief executive (system

142 *Hospital and Health Boards Act 2011,* s 53C.
143 *Hospital and Health Boards Act 2011,* s 53D.
144 *Hospital and Health Boards Act 2011,* s 53.
145 *Hospital and Health Boards Act 2011,* s 53G.
146 *Hospital and Health Boards Act 2011,* s 53H.
147 *Hospital and Health Boards Act 2011,* ss 8(3) and 45(c).

manager) and in alignment with the statewide plans.[148] That is, the HHS is under an obligation to provide the health services specified in its service agreement, and to do so to a standard to the satisfaction of the Department.

150. Whilst the provisions of service agreements empower HHSs to operate particular services (statewide or otherwise), that power does not necessarily of itself afford power to a HHS or HHB to shut down a service within its responsibility.

151. Rather, service agreements impose clear obligations on a HHB to continue to operate the services specified in their service agreement. The HHS may seek the agreement of the Department to make any amendment to the service agreement and, subject to the agreement of the system manager, execute a deed of amendment.

152. Importantly, a HHS must continue to perform and comply with its obligations under a service agreement until such time as it is relieved of that obligation by a deed of amendment.

Closure of the BAC - The WMHHS Service Agreement: 2013-2016

153. On 28 June 2012, West Moreton HHS (WMHHS) entered into a service agreement with the system manager for the three year period from 1 July 2013 to 30 June 2016 (the WM Agreement).[149]

154. The WM Agreement, now superseded, specified the services that the Department would purchase from the WMHHS during the 2013–14 financial year and provided an indication of activity for the two subsequent years.

155. Pursuant to the WM Agreement, the WMHHS assumed responsibility for a number of hospital facilities, including Boonah, Esk, Gatton, Ipswich and Laidley, as well as The Park Centre for Mental Health.

156. The WM Agreement required that the facilities and services outlined in schedules 1 and 2 to the agreement "continue to be provided" and that "buildings and infrastructure [be] maintained". Relevantly, schedule 1 to the WM Agreement contained a list of "Hospital Services and Facilities" to be provided by WMHHS, including statewide services.

148 *Hospital and Health Boards Act 2011,* s 19(2).
149 Exhibit 182, West Moreton HHS Service Agreement 2013/14 – 2015/16 [LJS.002.0001.0014].

157. That list expressly provided that the WMHHS was to operate the BAC:

> ***Statewide Services***
>
> ***The [WM]HHS has oversight responsibility for the following statewide services provided by The Park Centre for Mental Health****:*
>
> *a. extended treatment and rehabilitation/dual diagnosis;*
>
> *b. high security program;*
>
> *c.* ***adolescent unit services****.* [Our emphasis added].

158. The term "Statewide Service" is defined under the WM Agreement to mean:

> *"Services for the whole of Queensland provided from only one or two service bases within Queensland as self-sufficiency in these services cannot be maintained due to the inadequate volume of cases. The service may include a statewide regulatory, coordination and/or monitoring role."*[150]

159. The term "oversight role" is not defined under the Act nor in the WM Agreement.[151] However, by reference to the Act and provisions of the WM Agreement, we consider it can be understood to mean a role in providing for and running the BAC service. It is difficult to regard the "oversight role" as encompassing a right to close a facility. The concept of 'oversight' would ordinarily include supervision and watchful care, both of which are inconsistent with closure and thereby cessation of oversight responsibilities.

The Decision to Close

160. Having established that it was the obligation of WMHHS to operate and supervise the BAC service, the question is: who had the authority to decide to close it? Certainly there was no express power given to the WMHHS to close a service. And, as we have explained, a right to close is not encompassed by the expression "oversight role".

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[150] Exhibit 182, West Moreton HHS Service Agreement 2013/14 - 2015/16 [LJS.002.0001.0014].

[151] Dr Kingswell's evidence in respect of the oversight role of WMHHS can be found in his affidavit: Exhibit 68, Statement of William Kingswell, 21 October 2015 [DBK.900.001.0001].

161. The scheme of the Act is that the Department, through its chief executive as the system manager, retained residual responsibility for the public health system. That is clear from these provisions:

    (a) The overall management of the public sector health system remained the responsibility of the Department of Health (the Department) through its chief executive.[152]

    (b) Section 45 of the Act sets out the functions of the system manager, which include "to develop Statewide health service plans, workforce plans and capital works plans".

    (c) Sections 5 and 8 of the Act specify that when performing the system manager role, the system manager is responsible for statewide planning and managing major capital works.

    (d) Funding allocations to each HHS are centrally controlled by the system manager thus making it more likely that the power to start or stop a service rests with the system manager.

162. For those reasons, the likelihood is that it was the system manager who had the authority to close the BAC.

<u>The Practicalities</u>

163. Practically, the decision to close the BAC (both the building and the services run out of it) was a decision:

    (a) purportedly made by the WMHHB on 24 May 2013;[153]

    (b) made with the agreement of the Minister, by means of his apparent agreement with the decision, subject to some conditions, in a meeting on 15 July 2013, or by his office noting a briefing note on 31 July 2013 or by his public announcement on 6 August 2013; and

[152] *Hospital and Health Boards Act 2011,* s 8(2).
[153] See the discussion below on this topic.

(c) made with the support of the Department (and hence the system manager) and the agreement of Dr Kingswell (as chief executive of the Mental Health Alcohol and Other Drugs Branch).

164. Whilst the WMHHB were keen, subsequently, to ensure that its decision was seen as a conditional decision – that is, that the closure was subject to proper alternative services in place – it remains the case that the WMHHB accepted itself as having had the power to authorise the closure of the service.

165. However, as outlined above, it is clear from the provisions of the WM Agreement and the Act that the WMHHB was only entitled to amend its obligations under the WM Agreement with the agreement of the Department, documented under a Deed of Amendment.

166. WMHHS consequently remained under an obligation to provide the services outlined in the WM Agreement (which included the BAC) until and unless the system manager agreed to their removal from the WM Agreement.

Amendments to the WM Agreement: 2013-2016

167. The Commission has not been provided with any amendment proposal or Deed of Amendment which aligns with the timing of the decision by the WMHHB to close the BAC. It appears that this decision was made unilaterally by the WMHHB, albeit in (informal) consultation with Dr Kingswell on behalf of the Department.

168. While there is some reference in the material before the Commission to a Deed of Amendment dated November 2013, the Commission has been unable to locate a copy. In any event, a Deed of Amendment signed by the Department on 21 January 2014[154] continues to make express provision for the BAC service at The Park:

> *6.2.4 The HHS has* ***oversight responsibility*** *for the delivery of the following statewide (or multi-HHS) services:*
>
> - ***Adolescent Extended Treatment and Rehabilitation Centre (statewide)***

[154] Exhibit 627, Agreement - 2013/14 - 2015/16 Service Agreement - Deed of Amendment January 2014 [QHD.004.001.9119]. Note: The version available to the Commission has not been signed on behalf of the WMHHB.

- *High Security Inpatient Services (statewide)*

- *Extended Treatment and Rehabilitation Forensic unit (statewide)*

[Our emphasis added].

169. Strangely, that Deed of Amendment also inserts the following addition beneath the "hosted services" (to be provided by WMHHS):

"C) In section 6 'Mental Health and Alcohol and Other Drug Facilities and Services', sub-heading '6.2.6 Hosted Services' the following text is inserted at the end of the bulleted list:

- *The Statewide Adolescent Extended Treatment and Rehabilitation (AETR) Implementation Strategy."*

170. As is apparent from earlier topics in this submission, the SW AETRI concerned the development of alternatives for the BAC, as opposed to any strategy for the cessation of the BAC.

171. A similar addition was made in respect of the service agreement between the Department and Children's Health Queensland HHS.[155]

172. In April 2014, a further Amendment Deed was prepared in respect of the WM Agreement, and signed on behalf of the Department on 23 April 2014.[156] Peculiarly, no amendment was sought at this time to remove reference to the BAC. The only change made to the HHS profile was in respect of *'telehealth services'* and *'clinical education and training'*. It would appear, therefore, that reference to the BAC remained in the WM Agreement despite the fact that the service had closed in January 2014.

173. Not until July 2014 was the BAC removed as an obligation imposed on the WMHHB.[157] That release of the obligation to operate the BAC occurred when the Department and

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155 Exhibit 245, CHQHHS 2013/4 - 2015/6 Service Agreement Deed of Amendment, January 2014, 3 January 2014 [LJS.002.0001.0001].

156 Exhibit 645, Agreement - 2013/14 - 2015/16 Service Agreement - Deed of Amendment dated 1 April 2014 [QHD.004.006.5032]. Note: the version available to the Commission has only been signed on behalf of the Department.

157 Some reference is made in the July 2014 Revision document to an amendment deed dated 30 May 2014, however a copy of this document does not appear to have been made available to the Commission.

WMHHB entered into a further Amendment Deed (signed in August 2014) and released the "July 2014 Revision" of the WM Agreement.[158] At this point, statewide services are listed to only include "High Security Inpatient Service (statewide)" and "Extended Treatment and Rehabilitation Forensic unit (statewide)" (that is, EFTRU). There is no suggestion that the provisions operated retrospectively.

174. Consequently, it remained the case that as at 31 January 2014 (being the date when the BAC closed), WMHHS remained under an obligation, pursuant to the WM Agreement, to provide and deliver the BAC at The Park. That was presumably because the WMHHB had not sought a removal of the BAC through an Amendment Deed, as required by the WM Agreement.

175. Practically, of course, a decision had already been made – with the Minister's agreement and the apparent (informal) consent of the Department (through Dr Kingswell) – that such services would no longer be delivered by WMHHS post January 2014.

176. Nevertheless, the lack of clarity about the legal responsibility for the decision seems to have translated to a lack of any rational process in the decision-making. That aspect is discussed below.

[158] Exhibit 183, West Moreton HHS Service Agreement 2013/14 - 2015/16, Deed of Amendment [LJS.002.0001.0062].

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

Background

177. The decision to replace the BAC was made as part of the Queensland Plan for Mental Health 2007-2017. It was accepted by a number of witnesses that the decision to replace the BAC was arrived at with the benefit of specialist expert advice.[159]

178. From a number of alternatives, Redlands was chosen as the preferred location for the replacement of the BAC.

179. What was proposed for Redlands was not the BAC.

Table A: Criticisms of the BAC model

Criticism of BAC	Proposed Redlands model
Standalone facility Isolated in clinical governance - needs to sit as part of a continuum of care within the broader CYMHS system[160]	**Adjacent to a hospital** – envisaged that Redland's Hospital would support acute medical emergencies and other medical issues that can be managed locally.[161] **Integrated into CYMHS continuum of care**.[162] Clinical governance to be incorporated within the QCH (the Mater in the interim period) – this would facilitate reporting relationships, clinical supervision, patient safety issues, staff development & conformity national mental health reform agenda.[163] Access to a range of specialists who could provide support.[164]
Length of stay average of 13 months[165] Dr Sadler's average of 9.5 months in his MOS, for endorsement 26 March 2009.[166]	**Length of stay specified**– 6 month targeted and phased treatment program[167] - in specific cases when the admission exceeded

159 See the evidence explained above in Part B.
160 Exhibit 72, Affidavit of Judi Krause, 26 November 2015 [JKR.900.001.0001] at [.0455].
161 Exhibit 72, Affidavit of Judi Krause, 26 November 2015 [JKR.900.001.0001] at [.0485].
162 Exhibit 72, Affidavit of Judi Krause, 26 November 2015 [JKR.900.001.0001] at [.0485].
163 Exhibit 72, Affidavit of Judi Krause, 26 November 2015 [JKR.900.001.0001] at [.0485].
164 Exhibit 72, Affidavit of Judi Krause, 26 November 2015 [JKR.900.001.0001] at [.0486].
165 This figure is calculated on the 41 patients referred to by Counsel Assisting in the Opening.
166 Exhibit 179, Supplementary affidavit of Trevor Sadler, 12 February 2016 at Attachment A [DTZ.900.002.0001].
167 Exhibit 72, Affidavit of Judi Krause, 26 November 2015 [JKR.900.001.0001] at [.0486].

Criticism of BAC	Proposed Redlands model
	6 months, this was to be presented to an intake panel for review.[168]
CYMHS referral or private psychiatrist. Dr Sadler says a comprehensive clinical assessment occurred prior to the decision to admit - MOSD meeting 10 Feb 2010 BAC "*referral criteria/ exclusion criteria unclear*."[169]	**Refined referral process**[170] Referrals to be reviewed by a multidisciplinary intake panel[171] – *"build upon existing comprehensive assessment of the adolescent (obtaining a thorough treatment history from service providers and carers) with a view to assessing the likelihood of therapeutic gains by attending"*[172]
Therapies were listed but no particular sense of the continuum of care, the progression of therapies –this needed to be more clearly defined.[173]	**Refined treatment process**[174] Suite of evidence based treatments tailored to suit the individual's needs.[175]
Discharge planning commenced only on review of therapeutic and developmental progress.[176]	**Refined discharge process**[177] More "assertive" discharge planning to commence at point of admission, including addressing potential significant obstacles to discharge.[178]
Long waiting times[179]	**Proposed 3-6 month timeframe for admission**[180]
No family accommodation or step down accommodation	**Therapeutic residential and step down accommodation and a family stay unit**[181]

168 Exhibit 665, Child and Youth Mental Health Service, Adolescent Extended Treatment and Rehabilitation Centre, Draft Model of Service, dated 31 August 2011 [QHD.006.004.6106].
169 Exhibit 72, Affidavit of Judi Krause, 26 November 2015 [JKR.900.001.0001] at [.0429].
170 Exhibit 72, Affidavit of Judi Krause, 26 November 2015 [JKR.900.001.0001] at [.0486].
171 Exhibit 72, Affidavit of Judi Krause, 26 November 2015 [JKR.900.001.0001] at [.0486].
172 Exhibit 665, Child and Youth Mental Health Service, Adolescent Extended Treatment and Rehabilitation Centre, Draft Model of Service, dated 31 August 2011, p 1. [QHD.006.004.6106].
173 Exhibit 72, Affidavit of Judi Krause, 26 November 2015 [JKR.900.001.0001] at [.0429].
174 Exhibit 72, Affidavit of Judi Krause, 26 November 2015 [JKR.900.001.0001] at [.0486].
175 Exhibit 72, Affidavit of Judi Krause, 26 November 2015 [JKR.900.001.0001] at [.0486]; Exhibit 665, Child and Youth Mental Health Service, Adolescent Extended Treatment and Rehabilitation Centre, Draft Model of Service, dated 31 August 2011[QHD.006.004.6106].
176 Exhibit 189, Second supplementary affidavit of Trevor Sadler, 17 February 2016, Attachment A [DTZ.900.003.0001]; Exhibit 72, Affidavit of Judith Krause, 26 November 2015, Attachment Y [JKR.900.001.0001].
177 Exhibit 72, Affidavit of Judi Krause, 26 November 2015 [JKR.900.001.0001] at [.0486].
178 Exhibit 72, Affidavit of Judith Krause, 26 November 2015 [JKR.900.001.0001] at [.0486].
179 Exhibit 72, Affidavit of Judith Krause, 26 November 2015 [JKR.900.001.0001] at [.0430].
180 Exhibit 72, Affidavit of Judith Krause, 26 November 2015 [JKR.900.001.0001] at [.0430].
181 Exhibit 189, Second supplementary affidavit of Trevor Sadler, 17 February 2016, Attachment A [DTZ.900.003.0001].

Briefing Note of May 2012

180. The briefing note of May 2012 was prepared by Dr Geppert, cleared by Dr Kingswell and verified by Dr Young, and sought approval from the Director-General to cease the Redlands Adolescent Extended Treatment Unit capital program (the Redlands project), which was the proposed replacement of the BAC. That briefing note was signed and thus approved by Dr O'Connell on 16 May 2012.

181. The briefing note records that the approval was critical because:

> *"A Cabinet Budget Review Committee (CBRC) Submission has been prepared on the Project Agreements for capital projects approved for Queensland health under the Health and Hospitals Fund 2010 Regional Priority Round (HHF), and is potentially to be submitted In the week beginning 14 May 2012 - the strength of this CBRC Submission is reliant on the information in this Brief being approved and noted."*

182. Under the heading *'Headline Issues'* is this:

> *"The top three issues are:*
>
> - *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."

183. The briefing note includes this reasoning under the headings "Background" and "Consultation":

*"**Background***

> *6. The RAETU is one of the 17 projects funded under Stage 1 of the Queensland Mental Health Capital Works Program, and is intended to replace the Barrett Adolescent Centre, which is currently located at The Park Centre for Mental health (The Park).*
>
> *7. Ceasing 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. Limited sector consultation supports this review.*

Consultation

> *8. Consultation regarding this Brief has included Health Planning and Infrastructure Division, Queensland Health (QH); limited consultation within the mental health sector; and the Intergovernmental Funding and Policy Coordination Unit, Strategic Policy, Funding and Intergovernmental Relations Branch, QH.*
>
> *9. Further consultation will be conducted upon approval to proceed."*

184. The briefing note is remarkable, not for its content, but for the lack of supporting reports or information. As explained above, the decision to replace the BAC was a decision made with the involvement of experts under the QPMH. And yet the decision to cancel that decision is said to have been made with no support from experts and no identifiable "sector consultation".

185. That Dr Kingswell, Dr Geppert and Dr Young were confident enough to put such a proposition to Dr O'Connell in the absence of supporting information and expertise is surprising.

186. When Dr O'Connell came to consider the briefing note, he relied on the views of the deputy Directors-General:

> *"Was the decision to cease Redlands, to your knowledge, based on any expert views? Well, I believe it was based on the views which the relevant deputy DGs had sought to write the proposal. And I think it's worth noting that this wasn't an all or nothing decision in terms of the provision of extended care services. Those extended care services continued at the Barrett Centre. It just meant that they were occurring in a building which was old."*[182]

187. He agreed that the original plan is likely to have involved expert advice:

> *"The original plan was based on – sorry. You may not have been a part of Queensland Health at the time but you would have assumed that the Queensland Plan for Mental Health and the provisions in it were supported by expert advice for each of the different segments? Yes. Generally speaking, plans which are of that import are – are well socialised with content experts, expert clinicians before they're – before they're ready – or before they're finalised."*[183]

188. That original expert advice was, in effect, disregarded for three reasons: multiple delays, budget overruns of $1.4 million, and unidentified recent sector advice. Each of those three reasons is unsupported in the sense that no direct information was obtained from Professor Crompton and his team.

189. Each of the reasons for the decisions are explained in some detail in the attached **Table 4C**. In each case, the evidence of both confirmatory indications and contra-indications are set out.

190. Mr Springborg's evidence on this aspect is worth comment. Mr Springborg does not recall whether he received the May 2012 briefing note. However, he does recall that in 2012 he became aware that senior clinicians in the department had expressed the view

[182] Transcript, Anthony O'Connell, 23 February 2016, p 12-19 lines 16–22.
[183] Transcript, Anthony O'Connell, 23 February 2016, p 12-20 lines 24–29.

that the BAC was not regarded as a contemporary model of care.[184] In other words, Mr Springborg's conversations within the Department suggested a different reason to the three reasons stated in the May 2012 briefing note.

191. Dr Cleary's evidence about the reasons for the decision to cease the Redlands project is similar. He says he was told by Dr Kingswell that the proposed model of care for Redlands was not now considered to be contemporary.[185]

192. The evidence that the model of care proposed for Redlands was not considered contemporary is considered in Table 4C. It is suffice to say that:

(a) no child and adolescent expert subscribes to the theory (see the discussion above);

(b) the theory that the Redlands model of care was not contemporary was not raised with Professor Crompton and his team who were actually preparing the new model of care for Redlands;

(c) the theory is raised as a slogan without any specific detail (e.g. what aspect of the model is not contemporary and why?).

193. In emails, Dr Kingswell supported the theory by reference to the draft National Mental Health Service Policy Framework (NMHSPF), but that conflicts with Dr Groves' evidence and is inconsistent with the document itself because:

(a) The NMHSPF Project Charter specifies that "long stay" services are included;[186]

(b) Under the heading "Not all but many", the NMHSPF expressly provided that it will not account for every circumstance or service possibly required by an individual or group;[187]

(c) The NMHSPF expressly provided that:

"*The Taxonomy is simply a classification system and although it is divided into 'Service Streams' for convenience, there is absolutely NO intention for this to be construed as to be supporting any particular sector or format for these*

184 Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, para 40 [LJS.900.001.0001].
185 Transcript, Michael Cleary, 25 February 2016, p 14-8 lines 17–23.
186 Exhibit 375, NMHSPF – Project Charter dated 27 January 2015 [DBK.500.002.0001].
187 Exhibit 378, NMHSPF Project Communique – Issue 1 dated September 2011 [DBK.500.002.1062].

services to be provided. The NMHSPF is very much limited to 'function' and 'resources' and not the provider or service environment in which function may be performed. " [Emphasis in the original];[188]

(d) In any event, the NMHSPF does include specific mention of the BAC and does include a service element 2.3.2.5 – Sub-acute intensive care (*hospital*).

194. In any event, the NMHSPF is a draft and is not available to the profession. Interestingly, neither Dr Cleary nor Dr Stathis had a copy.[189] It is not complete and work on it continues. On that basis, it is odd to use that draft as evidence that a particular service is no longer contemporary and to do so without seeking the advice of a child and adolescent psychiatrist.

195. There is another possible influence on the decision. Dr Cleary noted that the Department had been required to find $120 million in savings.[190] That evidence is explained in detail in **Table 4C**. There is no direct evidence of that having altered the decision-making. Indeed, the briefing notes in May and August 2012 involve re-allocation of funding rather than a drive for saving. Nevertheless, it may have been an influence.

196. The result is a decision that seems some distance from both a factual foundation and proper expert advice.

The August 2012 Briefing Note

197. On 28 August 2012 the Minister signed a further briefing note that approved a strategy for rectification of prioritised infrastructure for 12 rural hospitals.[191] The funding for that project included the funds allocated the ceased Redlands project.

198. The briefing note itself originated with Mr Vaun Peate, an officer within the Minister's office. He made the request for the briefing note on 10 August 2012. He requested action by 17 August 2012. The briefing note was described as urgent because there was to be a proposed announcement by the Minister on 19 August 2012. The author and verifier of the document were officers of the Health Infrastructure Branch of Queensland Health.

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188 Exhibit 233, National Mental Health Service Planning Framework (NMHSPF) "Service Elements and Activity Descriptions" dated October 2013 [DBK.500.002.0620].

189 Dr Stathis had two pages only.

190 Exhibit 40, Statement of Michael Cleary, 21 December 2015, para 32 [DMZ.900.001.0001].

191 Exhibit 40, Statement of Lawrence Springborg, 27 January 2016 at LJS-3 [LJS.900.001.0001] at [.0036].

There is no suggestion that Dr Cleary's Health Service and Clinical Innovation Division were involved in the preparation of the briefing note.[192]

199. The effect of the briefing note was to cease three projects, including Redlands, and to defer a fourth project, so that savings of $41 million could be achieved. Then, that $41 million in savings, and a further $10.58 million from "Closing the Gap" funding, was to be used for "the planned strategy for the targeted rectification of the prioritised infrastructure issues and subsequent planning for 12 rural hospitals".[193]

200. The project for the 12 rural hospitals was relatively undeveloped. There were no contracts or approvals or quotations. The briefing note speaks of "An initial low confidence estimate of $51.58 million."[194]

201. Mr Springborg remembers receiving and signing the briefing note.[195] He said he did so because he had advice that Redlands was not the appropriate model of care:

> *"Alright. Now, I gather one of the reasons you remember this is because it was an important matter? It was a decision which involved removing $41 million from four projects, including Redlands; correct? There – I do remember this issue because there was discussion at the time around whether this was the right model of care for those who need care going forward. The advice on that was that it was no longer, and that was the advice by very senior clinicians. And as a consequence of that, the decision which had been made in May of that year by the director-general, acting on the advice of the chief health officer and the now-director of mental health and alcohol and drugs, was that this was not the appropriate model of care and the project should be ceased…"*[196]

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[192] Transcript, Lawrence Springborg, 26 February 2016, p 15-7 lines 8–12.

[193] Exhibit 40, Affidavit of Lawrence Springborg, 27 January 2016, Exhibit LJS-3 to that affidavit, Briefing Note for Approval to The Honourable Lawrence Springborg MP, Minister for Health, Subject: 12 Rural Infrastructure Projects, dated 16 August 2012, p 36 [LJS.900.001.0001] at [.0036]

[194] Exhibit 40, Affidavit of Lawrence Springborg, 27 January 2016, Exhibit LJS-3 to that affidavit, Briefing Note for Approval to The Honourable Lawrence Springborg MP, Minister for Health, Subject: 12 Rural Infrastructure Projects, dated 16 August 2012, p 36 [LJS.900.001.0001] at [.0036]

[195] Transcript, Lawrence Springborg, 26 February 2016, p 15-3 lines 29–39.

[196] Transcript, Lawrence Springborg, 26 February 2016, p 15-4 lines 15–24.

202. It is certainly likely that Dr Kingswell had recommended the cessation of the Redlands project. That is recorded in paragraph 14 of the briefing note. Dr Young had signed the briefing note as Acting Director-General.

203. The problems with the decision are these:

(a) there were no documents or reports or advice which recorded the advice to the Minister that the Redlands project was “not the appropriate model of care and the project should be ceased”;

(b) there were no documents or reports which addressed the consequences of the decision to cancel three projects and defer a fourth project;[197]

(c) that must have made it difficult to perform a balancing exercise which assessed the competing demands for the $41 million in taxpayers money;[198]

(d) there was limited consultation, no apparent consultation with appropriately qualified exerts,[199] and no consultation with either West Moreton or Metro South HHS.[200]

204. On the evidence the likelihood is that this was a political decision, made by the Minister without any analysis or balancing of competing demands. Further, the likelihood is that the Minister made the decision without any advice from Queensland Health and without any consideration of the consequences for the four cancelled or deferred projects.

205. It may well be within the Minister’s discretion to cancel and defer those four projects in favour of rectification of the infrastructure of 12 rural hospitals. But it is more than a little surprising that the decision is not supported by any reports, or analysis, or detailed consultation and that there is not a hint of advice or caution from the department, let alone from Dr Kingswell or Dr Young.

WM Decision on 24 May 2013

197 Transcript, Lawrence Springborg, 26 February 2016, p 15-16 lines 37–41. (Mr Springborg did not recollect that there were any reports or documents produced at this time but he said there was information available to ‘us’ at the time which assisted in making the decision.)

198 Transcript, Lawrence Springborg, 26 February 2016, p 15-17 line 40.

199 Dr Kingswell is not a child and adolescent psychiatrist.

200 Transcript, Lawrence Springborg, 26 February 2016, p 15-11 lines 4–8.

206. On 24 May 2013 the WMHHB (also referred to as 'the board') decided (albeit in opaque terms) to close BAC. Subsequently, on 31 July 2013 the Minister's chief of staff signed as "noted" a briefing note recording the WMHHB's approval of the closure of BAC, dependent on alternative appropriate care. The decision was then announced by the Minister on 6 August 2013.

207. It is necessary to look in some detail at the board meeting on 24 May 2013. Ms Kelly prepared the Agenda Paper for this meeting in advance.[201] This document attached both the recommendations of the ECRG and the Planning Group. However, in the Agenda Paper Ms Kelly put a number of matters to the WMHHB, including six propositions, namely:[202]

(a) **The Planning Group having accepted all (ECRG) recommendations with some caveats.**

In fact, the Planning Group does not appear to have formally met to consider the ECRG report. There are no minutes of any Planning Group meeting after the receipt of the ECRG report.[203] Some handwritten notes record feedback from four members of the Planning Group - Dr Stathis, Dr Sadler, Dr Kingswell and Michelle Bond.[204] But there is no recorded feedback from the other members of the Planning Group - Ms Kelly, Mr Thorburn, Dr Geppert, Dr Hartman or Ms Ford.

And, it is something of an exaggeration to say that the Planning Group accepted all recommendations of the ECRG with some caveats. In fact, the Planning Group were unconvinced about the ECRG's central proposition that a tier 3 facility was essential.[205]

(b) **The ECRG's service model elements document (and associated recommendations for an alternative model of service) allowed for safe and timely closure.**

201 Exhibit 41, Statement of Mary Corbett, 23 October 2015 [WMS.9000.0001.0001] at [.00020].
202 The propositions are in bold; commentary is added.
203 Transcript, Mary Corbett, 18 February 2016, p 9-49 lines 15–43
204 Exhibit 222, Handwritten Notes of Barrett Adolescent Strategy Planning Group dated 24 May 2013 [WMS.6002.0001.00025].
205 Exhibit 50, Statement of Timothy Eltham, 9 December 2015 [WMB.9000.0002.00001] at [.00176].

In fact, there is no such provision.

(c) **It was "clinically adequate to provide a four month timeframe to complete discharge planning" with the aim of closing the BAC by 30 September 2013.**

In fact, there is no such advice from anyone with any clinical expertise.

(d) **The closure of the BAC was not dependent on a new statewide service model.**

In fact, the ECRG warned of risks if the BAC closed without the availability of a new tier 3.[206]

(e) **The closure process was relevant to the needs of the current and wait-list BAC consumers, and the capacity for 'wrap-around'.**

In fact, the ECRG warned that closing of the BAC, without a new tier 3, carried a risk which needed to be ameliorated by 'wrap around' services in the interim whilst a new tier 3 was established (in a timely way).[207]

(f) **The Planning Group noted that this (presumably, the closure) was feasible to commence now.**

Only Dr Kingswell seems to have said this.[208]

208. Of particular concern is that what Ms Kelly was proposing in the Agenda Paper was contrary to the ECRG's recommendations (attached to the Agenda Paper). Whilst the ECRG had found that a tier 3 was essential, and had warned that interim service provision in the absence of a tier 3 was associated with risk, Ms Kelly proposed a four month timeframe for closure and a closure quite independent of any new service model. Certainly, neither Dr Corbett nor Mr Eltham (the chair and deputy chair) appear to have noticed any inconsistency between the ECRG's views and the proposals in the Agenda Paper.

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206 Exhibit 50, Statement of Timothy Eltham, 9 December 2015 [WMB.9000.0002.00001] at [.00050].
207 Exhibit 50, Statement of Timothy Eltham, 9 December 2015 [WMB.9000.0002.00001] at [.00050].
208 Exhibit 222, Handwritten Notes of Barrett Adolescent Strategy Planning Group dated 24 May 2013 [WMS.6002.0001.00025] at [00029].

209. There is no evidence of any debate or consideration by the WMHHB of the content of the Agenda Paper. For example, the Agenda Paper stated that the capital project for a replacement BAC had ceased due to "unresolvable building and environmental barriers". There is no evidence that any WMHHB member asked what the barriers were and why they could not be resolved. Presumably, those statements were accepted.

210. Of course, the statement of fact that Redlands had ceased because of "unresolvable building and environmental barriers" is not supported by any evidence.

211. Another example is the proposition that closure of the BAC aligned with the "strategic direction of the HHS and the Queensland Plan for Mental Health 2007-17." Ms Kelly does not identify any factual basis for that proposition and there is no evidence of any debate about it by the WMHHB.

212. Ms Kelly appears to have no proper basis for stating either of those propositions.

213. We turn now to the meeting minutes themselves.[209] Read in isolation, the action items in the minutes for the May 2013 meeting are obtuse. No actual decision to close the BAC is specifically recorded. However, the combination of the various items of the minutes makes it clear that a decision was taken at this meeting to close the BAC (or, at the very least, a decision to move towards closure). The meeting minutes note that the WMHHB was concerned that there was currently no alternative for consumers. Notwithstanding this, the Minister was to be "updated regarding proposed closure" (which assumes a decision to close) and steps were to be taken to cease further admissions and to "pursue discharge of appropriate current patients" (which are steps towards closure). Ultimately, a decision was taken to approve the development of a communication and implementation plan to support the proposed closure – in other words, a plan to create a plan.

214. There is no evidence that Dr Corbett and Mr Eltham properly read or noted the views of the ECRG. The decision that was taken was contrary to the recommendations of the ECRG. In the course of their oral evidence, Dr Corbett and Mr Eltham were both taken to the ECRG report. Mr Eltham agreed that the ECRG said that a tier 3 was essential and should be prioritised.[210] He agreed that interim services if the BAC closed in the absence

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209 Exhibit 41, Statement of Mary Corbett, 23 October 2015 [WMS.9000.0001.0002] at [.00020].

210 Transcript, Timothy Eltham, 18 February 2016, p 9-5 line 44 – p 9-6 line 1.

of a tier 3 was associated with risk.[211] Dr Corbett agreed that the ECRG were saying that a tier 3 was essential and should be prioritised.[212] Dr Corbett agreed that if there was an interim period after the BAC was closed and before another tier 3 was in place, this was associated with risk. And yet, neither board member appears to have recognised that at the time.

215. Another curiosity in the minutes is that the WMHHB "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." There is no record of any such recommendation or a need to move rapidly to a new model. In fact, there is no Planning Group report *per se*, let alone any analysis by that group.[213] Rather, the Planning Group made comments in the right hand column of the ECRG Report.

216. In the circumstances, the WMHHB's decision to proceed with the closure of the BAC is inexplicable. Also inexplicable is the apparent lack of scrutiny or debate.

217. Mr Eltham's evidence is that there was "discussion" at the May board meeting about "whether the Board would be able to ensure that there was going to be adequate care for the residents of the BAC if they had to make a transition to alternative care arrangements".[214] In his statement, Mr Eltham identifies his concerns, which included that he was aware that there were no other long-stay residential facilities like the BAC in Queensland.[215] He said he was concerned to know what support would be provided to existing patients and wanted reassurance that their needs would be met under the arrangements to which they would be transitioned.[216] In fact, Mr Eltham had sent an email to Dr Corbett some months earlier, on 8 November 2012, in which he stated it was "absolutely shameful that there were no funds allocated anywhere for the service that the BAC has been providing".[217]

218. Mr Eltham stated "the ECRG and the Planning Group confirmed it was possible to provide appropriate and safe services, so what the WMHHB wanted was detail of how

211 Transcript, Timothy Eltham, 18 February 2016, p 9-6 lines 7–9.
212 Transcript, Mary Corbett, 18 February 2016, p 9-46 lines 5–15.
213 Transcript, Timothy Eltham, 18 February 2016, p 9-4 line 45.
214 Transcript, Timothy Eltham, 18 February 2016, p 9-2 lines 23–30; p 9-3 lines 1–3.
215 Exhibit 50, Statement of Timothy Eltham, 9 Dec 2015, para 21.1(a) [WMB.9000.0002.00001] at [.00025].
216 Exhibit 50, Statement of Timothy Eltham, 9 Dec 2015, para 21.1(a) [WMB.9000.0002.00001] at [.00025].
217 Exhibit 41, Statement of Mary Corbett, 23 October 2015 [WMS.9000.0001.0002] at [.00108].

that would be achieved. WMHHB supported closure of BAC contingent on detail being provided in that regard."[218] According to Mr Eltham that detail was provided in Agenda Papers and briefings at subsequent meetings of the WMHHB up to and including the meeting of the board on 20 December 2013.[219] Ultimately, Mr Eltham was satisfied that his concerns had been addressed.[220] However, it is difficult to see what it was that satisfied him about that.

219. Similarly, Dr Corbett's evidence is that "the WMHHB consistently held the position that any nominated date for closure of BAC was contingent upon the safe and appropriate transition of patients".[221] In her oral evidence, Dr Corbett stated that the board "were assured that there was no gap to service and that appropriate … wraparound services were available".[222] When asked how they were so assured, Dr Corbett's evidence was that they were "assured through liaison, through assurance of the services being provided, and also by the absence of any concerns that the services were not available".[223]

220. When one looks at the Agenda Papers, meeting minutes and oral evidence of Mr Eltham and Dr Corbett, it is difficult to see how they, or the WMHHB, could have been sufficiently satisfied. What emerged in oral evidence is that the WMHHB received superficial updates regarding the services that were to be available. When asked what services were available and when, both Mr Eltham and Dr Corbett were only able to give vague responses. There was certainly no precise delineation of what services were available and when. Mr Eltham spoke of a "centre up in Cairns" and "another centre in Metro South that offered some degree of additional support", but conceded that this was "not at the level described in the ECRG report".[224] Dr Corbett listed a "mobile outreach service", a "day program", a "holiday program" and "some acute beds".[225] She said she was not a clinician but she was "aware there were a number of services that were bundled

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218 Exhibit 50, Statement of Timothy Eltham, 9 Dec 2015, para 23.11 [WMB.9000.0002.00001] at [.00030].
219 Exhibit 50, Statement of Timothy Eltham, 9 Dec 2015, para 23.16 [WMB.9000.0002.00001] at [.00050].
220 Exhibit 50, Statement of Timothy Eltham, 9 Dec 2015, para 22.1 [WMB.9000.0002.00001] at [.00050].
221 Exhibit 41, Statement of Mary Corbett, 23 October 2015, para 18.5 [WMS.9000.0001.0002] at [.00028].
222 Transcript, Mary Corbett, 18 February 2016, p 9-50 lines 1–4.
223 Transcript, Mary Corbett, 18 February 2016, p 9-50 lines 18–20.
224 Transcript, Timothy Eltham, 18 February 2016, p 9-16 lines 28–31.
225 Transcript, Mary Corbett, 18 February 2016, p 9-51 lines 11–15.

in this wraparound care".[226] When asked, she could not recall the specific date for when the mobile outreach service became available nor the day program.[227]

221. Dr Corbett's evidence is that the WMHHB's "concerns regarding the appropriateness of the decision to close BAC" were that the board "were concerned to receive assurance that appropriate and safe alternative treatment options were available … WMHHB sought confirmation that future models of care which were being developed would adequately provide for the treatment of adolescents who might otherwise have been referred to the BAC."[228]

222. It was put to Dr Corbett that she could name a couple of services but that she could not say when they commenced or the features of each.[229] Dr Corbett stated that "the importance for the board was that these services were available to meet the needs of the patients … there was no indication they were not available to meet the patients' needs. So whatever those services were our understanding was they were available".[230] Dr Corbett's evidence is that the WMHHB sought assurance at each of its meetings that patients would be discharged or transitioned with appropriate care and that she received that assurance.[231]

223. It is hard to reconcile this evidence. If the WMHHB, and particularly Dr Corbett and Mr Eltham, were seeking assurances that alternative and safe options were available that could adequately provide for the BAC cohort, it is difficult to understand how they and the board could have been so assured if they did not receive a written report or know what the services were or when they would become available. If Dr Corbett and Mr Eltham and the WMHHB were not aware of what the services were, how could they have been satisfied that the needs of the BAC cohort were being met? Why did they impose such a condition and then not follow it through?

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226 Transcript, Mary Corbett, 18 February 2016, p 9-51 lines 14–16.
227 Transcript, Mary Corbett, 18 February 2016, p 9-51 line 29; p 9-51 line 40.
228 Exhibit 41, Statement of Mary Corbett, 23 October 2015, para 17.12 [WMS.9000.0001.0002] at [.00025].
229 Transcript, Mary Corbett, 18 February 2016, p 9-51 line 36.
230 Transcript, Mary Corbett, 18 February 2016, p 9-51 lines 40–43.
231 Transcript, Mary Corbett, 18 February 2016, p 9-54 line 5.

224. The WMHHB appear to have been unaware of any difficulties or problems encountered by Dr Brennan or Dr Hoehn and did not receive reports from either Dr Brennan or Dr Hoehn, because that was an "operational matter".[232]

225. Given that the new services were not in place (and would not be in place for some time), and Dr Corbett and Mr Eltham contended that the closure was conditional upon there being new services in place, it is surprising that neither Dr Corbett or Mr Eltham or any other board member said, in effect, 'stop' (the closure). If the closure was truly conditional on the availability of new services, why did WMHHS press ahead with the closure?

226. In evidence, Dr Corbett was asked how she become satisfied that there were, in fact, alternative models of care in place by December/January. She stated that the board papers for the meetings, particularly around November, "clearly" articulated the models of care that the services were adequate and said that there would be no gap in the services.[233] She refers to an attachment to the November board meeting.[234] This document is the 'WM HHS Transitional Service Options Plan.' It is sparse in detail and does not specify when each service is to come online. In fact, the Agenda Paper for the November meeting states that the WMHHB were informed that the new statewide service options could take a further 12 months to be fully established.[235] At that point, there was a plan to commence planning interim service options.

227. One curious aspect is Dr Corbett's evidence that patients that had already been transitioned out of the BAC *"*obviously didn't need the service option, otherwise they would not have been transitioned".[236] There are some extraordinary assumptions in that evidence. It seems not to have occurred to Dr Corbett that Dr Brennan and the transition team were actually conducting the transitions on the basis of trying to adapt the BAC inpatients and waitlist patients to the existing services. In fact, Dr Corbett agreed that the WMHHB were relying on the fact that a transition had occurred as inferring that all had been done and the appropriate services were available to the young person.[237]

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232 Transcript, Mary Corbett, 18 February 2016, p 9-55 lines 27–38.
233 Transcript, Mary Corbett, 18 February 2016, p 9-57 lines 32–36.
234 Transcript, Mary Corbett, 18 February 2016, p 9-55 line 45.
235 Transcript, Mary Corbett, 18 February 2016, p 9-53 line 31.
236 Transcript, Mary Corbett, 18 February 2016, p 9-53 lines 44–45.
237 Transcript, Mary Corbett, 18 February 2016, p 9-54 lines 1–3.

228. This evidence is also inconsistent with a Consumer Feedback Summary Report dated October 2013, attached to the Agenda Paper for the 29 November 2013 board meeting. That feedback report states:

> *"seven of the sixteen complaints rated as moderate are related to the closure of the Barrett Adolescent Centre where the main emphasis of the feedback was predominantly about the uncertainty of future care and the model of care to be provided."*[238]

229. The Agenda Paper for the 20 December 2013 board meeting reads:

> *"twenty two of the twenty eight complaints rated as moderate are related to the closure of the Barrett Adolescent Centre where the main emphasis of the feedback was predominantly about the uncertainty of future care and the model of care to be provided."*[239]

230. Mr Eltham's evidence that it was his understanding that over the course of approximately eight months, the transition team "had developed for them individual … transition plans, rather, which included, **I hope**, I believe, a mix of services which were designed to support them"[240] [emphasis added]. When questioned about the wraparound services that were available or the type of consumers that were able to access those services, Mr Eltham conceded that there was no precise delineation of "wrap around" services that might have been provided for those patients.[241]

231. In summary, it is concerning that the WMHHB appear to have arrived at a decision to close the BAC based on an Agenda Paper produced by Ms Kelly, a document which is based on propositions which lack any factual foundation. The ECRG's report attached to this Agenda Paper is not equivocal. And, the Planning Group did not recommend a need to move rapidly to an alternative model. Therefore, the decision of the board was misinformed. The board made an active decision to close the BAC when they had an expert and stakeholder panel warning against it.

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238 Exhibit 41, Statement of Mary Corbett, 23 October 2015 [WMS.9000.0001.0002] at [.00215].
239 Exhibit 41, Statement of Mary Corbett, 23 October 2015 [WMS.9000.0001.0002] at [.00243].
240 Transcript, Timothy Eltham, 18 February 2016, p 9-9 lines 45–48; p 9-10 lines 1–4.
241 Transcript, Timothy Eltham, 18 February 2016, p 9-10 lines 11–19.

232. Now to the proposition that the board imposed a condition that the closure of the BAC was contingent upon safe and appropriate services. It is difficult to see how any such condition was imposed by the board given nothing in the minutes articulates what was to be done to address the board's concern that there was currently no alternative for consumers except that there be a "plan for development of alternatives". This plan for a plan to develop alternatives lacked any real conviction. At the time they imposed the condition, there is no evidence as to how the board intended to satisfy themselves of this condition. And, if any such condition was imposed, at the meeting (despite the minutes), it lacked any conviction or follow up. Instead, Dr Corbett and Mr Eltham were content with superficial updates received at subsequent Board Meetings and associated Agenda Papers.

233. Assuming a condition *was* imposed by the board, the evidence of Dr Corbett and Mr Eltham makes it likely that there was no proper inquiry made about *what* services would be available to the BAC cohort, and *when*. In the circumstances, it is difficult to see how the board satisfied themselves that appropriate and safe alternatives were in place.

234. On 31 July 2013 the Minister's chief of staff signed as 'noted' a briefing note recording the WMHHB's approval of the closure of the BAC dependent on alternative, appropriate care. In his statement, Dr O'Connell draws a distinction between a brief for 'noting' and a brief for 'approval'. Dr O'Connell's evidence is that the subject briefing note was "for the purpose of the D-G to note the proposed actions by the West Moreton HHS". Dr O'Connell's evidence is that the note was not asking the Director-General's "approval for the HHS to proceed with its intentions", rather, it was intended to provide information, "given the sensitive nature of the issue."

235. The decision to close the BAC was then announced by the Minister on 6 August 2013.

236. Of course, as explained in Part D above, there is some doubt that the board had the legal authority to close the BAC.

<u>Education</u>

237. From the evidence presently available to Counsel Assisting, it appears that the Department of Education, Training and Employment (the DETE) (as it then was) did not have any role or involvement in the decision to close the BAC. On 8 November 2012,

Mr Peter Blatch, former Assistant Regional Director, School Performance within the DETE, was advised informally by Dr Sadler that the BAC was likely to close, however no time frame was given.[242]

238. This likelihood of the BAC closing was confirmed by Ms Kelly in a telephone call a few days later. In his oral evidence, Mr Blatch stated that the DETE could not commence making alternative arrangements regarding the future of the BAC School until they knew what the new model of mental health provision was going to be.[243]

239. On 19 July 2013, Mr Blatch sent an email update to Ms Patrea Walton, Deputy Director General, State Schools, informing her that the decision to close would be announced by the Department of Health within the following two weeks. In that email he stated that "DETE had not been involved in any discussions and were totally unaware prior to the [closure leak]".[244]

240. In his oral evidence Mr Blatch stated that he would have hoped for earlier consultation regarding the closure decision. He further stated that he was not sure if WMHHS had realised that the BAC School was actually part of the DETE.[245]

241. Neither Mr Kevin Rodgers, the BAC School Principal, nor Ms Deborah Rankin, the Acting BAC School Principal, provided evidence of being consulted or involved in any way in relation to the decision to close.

[242] Exhibit 25, Statement by Peter Blatch, 20 November 2015, p 12 para 32 [DET.900.001.0001] at [0012].

[243] Transcript, Peter Blatch, 25 February 2016, p 14-102 lines 15–21.

[244] Exhibit 25, Statement by Peter Blatch, 20 November 2015, p 12 para 32, Exhibit C [DET.900.001.0001] at [0033].

[245] Transcript, Peter Blatch, 25 February 2016, p 14-103 lines 44–47; p 14-104 lines 1–10.

PART F: THE REASONS AND INPUTS FOR THE DECISION TO CLOSE [TOR 3(b) & 3(c)]

242. As has been explained, there were a number of steps in the progression to the closure of the BAC.

Reasons and Inputs in May 2012

243. In May 2012, the Director-General, Dr O'Connell signed a briefing note approving the cessation of the Redlands project. He did that explicitly on the basis of multiple delays, budget overruns and a re-scoping of the service model and governance structure. However, in evidence, Dr O'Connell said he relied on the views of the relevant deputy Directors-General who had written the proposal (presumably Dr Young and Dr Kingswell). Mr Springborg also referred to discussions with "senior clinicians" which described the Redlands model of service as inappropriate and as not contemporary.

244. Dr Cleary said he was told by Dr Kingswell that the proposed model of care was not now considered to be contemporary.

245. And so, at this point, whilst the briefing note recorded three specific reasons, the decision-makers relied on various unidentified discussions and oral advice, probably by Dr Kingswell, to the effect that what was proposed for Redlands was not contemporary. The reasoning or basis for that advice is not identified. Plainly, Dr Kingswell had strong views about the BAC,[246] but he was unclear about whether there was a final model of service for Redlands.[247] Certainly, Dr Kingswell's criticism of the model of service does not appear to be grounded upon a specific model of service.

Reasons and Inputs in August 2012

246. It was Mr Springborg who signed the August 2012 briefing note. This briefing note does not explicitly say why the Redlands project was to be cancelled, although it does say that the cancellation had the recommendation of Dr Kingswell.

[246] Transcript, William Kingswell, 24 February 2016, p 13-19 lines 22–29.
[247] Transcript, William Kingswell, 24 February 2016, p 13-14 lines 23–40.

247. Mr Springborg's evidence is that he had advice from "very senior clinicians" that the Redlands model of service was not considered contemporary. [248]

248. Mr Springborg's reference to "very senior clinicians" appears to be a reference principally to Dr O'Connell, Dr Kingswell, and perhaps Dr Cleary.[249]

249. Again, the reliance is on unidentifiable conversations – probably informal conversations. There was apparently no thought that the advice should be documented, or that the reasoning should be explained, or that child and adolescent psychiatric advice should be sought.

250. The August 2012 briefing note involved the reallocation of $41 million from four South East Queensland projects to 12 rural hospitals. It is extraordinary that at least part of that re-allocation was based only on informal and unidentified conversations.

251. Mr Springborg explained that, in this situation, you "assimilate and accumulate" information based on the sources and advice that you receive.[250] That is an unsound basis for a decision involving this much public money and a matter that plainly involves clinical expertise.

<u>Reasons and Inputs in May 2013</u>

252. The WMHHB decision on 24 May 2013 is in a different category. The board's minutes record that:

> *"The Board discussed the recommendation from the Planning Group that proposes the closure of the Barrett Adolescent Centre (BAC) and the issues that this presents. The Board recognised that the Barrett facility is no longer suitable but is concerned there is currently no alternative for consumers. The Board noted the strategy of the Barrett Adolescent Strategy Planning Group, and the need to move as rapidly as possible to an alternative model based on those recommendations".*[251]

253. This suggests that:

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248 Transcript, Lawrence Springborg, 26 February 2016, p 15-4 lines 15–24.
249 Transcript, Lawrence Springborg, 26 February 2016, p 15-27 lines 1–21.
250 Transcript, Lawrence Springborg, 26 February 2016, p 15-27 lines 1–21.
251 Exhibit 41, Statement of Mary Corbett, 23 October 2015 at [WMS.9000.0001.0002] at [.00173].

(a) it was the Planning Group that was recommending closure;

(b) the facility is no longer suitable – this possibly refers to the physical condition of the building or to the co-location with EFTRU.

254. In other words, the WMHHB considered the advice of the Planning Group, and recognised the unsuitability of the building and its location, but were concerned by the lack of alternatives.

255. As explained above, there are a number of problems with this. The first is that the actual recommendations of the Planning Group are difficult to discern. In reality the Planning Group made comments and notes on the recommendations of the ECRG.

256. The second is that the Planning Group did not positively recommend closure, although they did comment that the process could commence.

257. The third is that the unsuitability of the BAC was not identified – at least in the minutes.

258. The fourth is the complete absence of any considerations of the views of the ECRG.

259. The fifth is that, as explained above, the decision appears to be based on an Agenda Paper that was not scrutinised and was plainly inaccurate or misleading.

260. In short, whilst the physical structure of the building (which had deteriorated whilst the Redlands project had proceeded) and the co-location with EFTRU may have been reasons motivating the board, a probable important reason was the perception that the Planning Group had considered the issues and was recommending closure. In fact, all the Planning Group had done was to comment upon the views of the ECRG – which warned of the risk if the BAC was closed without another tier 3 facility being available.

261. The board's decision is a superficial one – probably based on the presentation of Ms Kelly and Ms Dwyer and on an agenda paper which was inaccurate or misleading.

262. Another relevant point is that the WMHHB plainly appreciated that the BAC did not have the support of the Department and so, in reality, the likelihood was that they would cease

to receive funding for it. That lack of funding was a matter Mr Eltham had thought "shameful" in his email of 9 November 2012.[252]

Governance

263. One reason propounded as a reason for the closure of the BAC was a lack of governance.

264. That was not a reason for closure. Dr Kingswell's statement records the lack of governance as a reason for closure.[253] However, the events suggesting a lack of governance post-dated the decision to close. Dr Kingswell retreated (a little) in his evidence saying that the incident "accelerated the need to close (BAC)".[254]

265. Some cross-examination by counsel for West Moreton suggested that governance was a reason for closure. However, the minutes of the board do not suggest that as a reason. It was not put forward as a reason at the time, and it is difficult to understand how issues with governance are a reason to close a health facility rather than a reason to fix the governance issues.

266. Of course governance of the BAC was a matter for which West Moreton was responsible. If there had been genuine concerns, no doubt they could and would have acted to rectify the governance concerns.

Conclusions

267. It follows that there were a variety of reasons and inputs into the decision to close the BAC.

268. The decision making was fragmented and involved:

    (a) discussions and reasoning which was not documented;

    (b) no proper grounding in facts;

    (c) a lack of scrutiny of facts;

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[252] Exhibit 50, Statement of Tim Eltham, 9 December 2015, para 11 [WMB.9000.0002.0001] at [00009].

[253] Exhibit 68, Statement of William Kingswell, 21 October 2015, para 20 (v) [DBK.900.001.0001] at [.0007].

[254] Transcript, William Kingswell, 24 February 2016, p 13-4 line 45.

(d) no resort to appropriate expertise – even when a report was available; and

(e) a lack of proper, careful analysis of the issues.

269. A consequence was that, whilst the ECRG was saying in clear terms that a tier 3 facility was essential, in fact both Queensland Health and the West Moreton HHB acted to remove the remaining tier 3. This is in the context where both Mr Springborg and Dr Cleary say that, had they known that a tier 3 was essential, the funds could be found for it.[255]

[255] Exhibit 120, Statement of Lawrence Springborg, 27 January 2016, para 71 [LJS.900.001.0001] at [.0015].

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

270. There are two possible interpretations of this TOR as outlined previously in Discussion Paper 4:

(a) the narrow interpretation – whether consideration was given to replacing BAC with a similar in-patient or subacute facility; and

(b) the wider interpretation – whether consideration was given to replacing BAC with any one or more of a wide combination of models of care.

271. We propose to adopt the wider interpretation, focusing separately on two different points in time:

(a) first, at the time when the decision was purportedly made by the WMHHB, on 24 May 2013, to approve the closure of the BAC; and

(b) second, at the time from the announcement of the decision by the Minister on 6 August 2013 up until the closure of the BAC in January 2014.

272. The first point in time is addressed below. The second point in time is dealt with separately in these submissions in the context of transition arrangements.

Consideration of replacement with a similar in-patient or subacute facility

273. The evidence shows that at the time of its decision on 24 May 2013, no consideration was given by the WMHHB to replacing BAC with a similar in-patient or subacute facility.

274. Whilst previously consideration had been given to the option of relocating BAC to the Redlands site, relocation was not an option contemplated at the time of the decision to close. In fact, this option had been expressly ruled "out of scope" both in the Terms of Reference for the ECRG and also the Project Plan.

275. The WMHHB Agenda Paper, prepared by Ms Kelly ahead of the meeting on 24 May 2013, records that the capital project for a replacement BAC had ceased due to

"unresolvable building and environmental barriers, and none of this capital funding is available to build the facility elsewhere".[256]

276. The fact that the BAC could not be replaced with a similar in-patient or subacute facility appears to have been accepted by the members of the WMHHB.

277. Ms Corbett's evidence is that:

> *"there was recognition through the Queensland Plan for Mental Health, and more widely, that the model of care for the future would be where patients receive care closer to home…there were imperatives to actually move towards alternative services …".*[257]

278. Mr Eltham's evidence in respect of the meeting on 24 May 2013 was that the WMHHB's first point was "to note the recommendations of the Barrett Adolescent Strategy Planning Group and the need to move as rapidly as possible to <u>an alternative model</u> based on those recommendations".[258] [Our emphasis added].

279. Peculiarly, the view that a tier 3 facility ought not be considered was a view held despite the express recommendation of the ECRG that a tier 3 facility was an "essential service component" and that interim service provision without a tier 3 facility was associated with risk.

280. Departing slightly from the chronology, the position not to consider the option of replacing the BAC with another similar facility appears to have been a decision made as far back as 2012, with Dr Kingswell having informed Dr Sadler on 27 March 2012 that a proposal to "shift the [Redlands] project ... [to Springfield] would create further delays rather than expedite matters" and would waste costs.[259]

<u>Consideration of other models of care</u>

281. The evidence to the Commission also shows that no real or considered thought was given by the WMHHB to alternative models of care at the time when the decision was made to

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256 Exhibit 4, Statement of Mary Corbett, 23 October 2015 [WMS.9000.0001.0002] at [.00020].
257 Transcript, Mary Corbett, 18 February 2016, p 9-46 lines 36–44.
258 Transcript, Timothy Eltham, 18 February 2016, p 9-3 lines 1–3.
259 Exhibit 651, Letter from Dr William John Kingswell to Dr Trevor Sadler dated 27 March 2012 [QHD.004.014.7257]; Transcript, William Kingswell, 24 February 2016, p 13-21 lines 33–39.

close the BAC. To the contrary, numerous witnesses have given evidence that this was a matter to be considered further at a later time and by others.

270.1 While the WMHHB made vague references (when approving the closure of the BAC) to replacement of the BAC with "wraparound care", there was never any precise delineation of what this notion of "wraparound care" would comprise or what services were to be made available.

271 The Agenda Paper prepared by Ms Kelly ahead of the meeting of the WMHHB recorded that the closure of BAC was "not dependent on a new statewide service model". Ms Kelly proposed a four month closure quite independent of any new service model. Consistent with this, Ms Kelly's evidence was that she had advised the WMHHB that closure of the BAC "was not reliant on a final, state-wide service model".[260]

272 The Minutes of the meeting of the WMHHB record that the board was concerned there was currently no alternative for closure and that the Minister was to be updated regarding the "plan for the development of alternatives".[261]

273 Ms Kelly's evidence was that "wraparound care" is "an individualised service plan" which involved "identifying the needs" and "an appropriate package of care or wrap-around service" to be developed individually by clinicians.[262]

274 Mr Eltham's evidence was that "Wraparound services is a generic term which is employed by a number of professionals and government departments, indeed, to describe the suite of services …".[263] Mr Eltham accepted that he was not "personally aware of the full gambit of services that would have been available **or could have been put together** in a wraparound model".[264] [Our emphasis]. His evidence was that "the health service was to pursue the discharge into wraparounds", and that he had no direct knowledge of what this involved.[265]

275 Dr Corbett's evidence was that alternative services had not been developed, however she "would have imagined that in the course of this [we assume, the closure process], a

260 Transcript, Sharon Kelly, 22 February 2016, p 11-17 lines 42–44.
261 Exhibit 41, Statement of Mary Corbett, 23 October 2015 [WMB.9000.0001.00001] at [.00020].
262 Transcript, Sharon Kelly, 22 February 2016, p 11-18 lines 1–12.
263 Transcript, Timothy Eltham, 18 February 2016, p 9-7 lines 28–30.
264 Transcript, Timothy Eltham, 18 February 2016, p 9-7 lines 38–40.
265 Transcript, Timothy Eltham, 18 February 2016, p 9-9 line 45; p 9-10 line l6; p 9-10 line 19.

number of opportunities were being pursued".[266] When asked what services were being contemplated, Dr Corbett's evidence was that she was not qualified to speak to what services may have been available and stated instead that it "was always the board's concern that there were appropriate services available".[267]

276 The alternative models of care that were considered by Queensland Health and Children's Health Queensland are addressed later in these submissions.

[266] Transcript, Mary Corbett, 18 February 2016, p 9-47 line 19.
[267] Transcript, Mary Corbett, 18 February 2016, p 9-47 line 45.

PART I: TRANSITION ARRANGEMENTS FOR TRANSITION CLIENTS [TOR 3(d) and 3(e)]

Anticipated closure of the BAC

Unofficial closure announcement

278. On 26 October 2012, Ms Kelly emailed Dr Kingswell and others stating that "the option is to close BAC as early as December 2012 given that all or most of the consumers all go home for the Christmas break" and mentions a "meeting planned for next Friday [2 November 2012]" between Ms Kelly, Dr Stedman and Dr Sadler. In this email, Ms Kelly states that "at this time we will advise that closure is not optional however needs to be planned."[268] Ms Kelly's evidence is that this was "an option. It wasn't a definitive decision". However, she concedes that what she was proposing to tell Dr Stedman and Dr Sadler at that time was "[t]hat the closure of the Barrett [is] part of the Plan for Mental Health and the creation of the adult-only services at The Park is not an option to change."[269]

279. On 2 November 2012, Ms Kelly told Dr Sadler and Dr Stedman that the MHAODB had decided to close the BAC on 31 December 2012.[270] Dr Sadler's evidence is that he does not recall any discussion about transition plans for the adolescents – his understanding was that the adolescents would "simply be relocated to acute inpatient units."[271] However, Ms Kelly's evidence is that Dr Sadler was the clinical director at the time, and he was to "go away and think about it".[272]

280. On 8 November 2012, Professor Brett McDermott let the "cat out of the bag" while giving evidence in the Queensland Child Protection Commission of Inquiry, when he said that the BAC was to close in December 2012.[273] This premature, unofficial announcement caught a number of people (including WMHHS executives, BAC staff,

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268 Exhibit 66, Affidavit of Sharon Kelly, 16 October 2015, Exhibit SK9 to that statement, Email from Sharon Kelly to Dr Bill Kinsgwell, Dr Jagmohan Gilhotra, Dr Leanne Geppert, copying in Lesley Dwyer and Chris Thorburn regarding "WMHHS and mental health plan" dated 26 October 2012 [WMS.9000.0006.00001] at [.00826].

269 Transcript, Sharon Kelly, 22 February 2016, p 11-6 line 17; p 11-6 lines 38–40.

270 Exhibit 112, Affidavit of Trevor Sadler, 11 December 2015, para 226 [DTZ.900.001.0001].

271 Exhibit 112, Affidavit of Trevor Sadler, 11 December 2015, para 226 [DTZ.900.001.0001].

272 Transcript, Leanne Geppert, 19 February 2016, p 10-11 lines 14–16.

273 Exhibit 84, Statement of Brett McDermott, 10 November 2015, paras 92-100 [PBM.001.002.001] at [.017] and [.018].

families and patients) off guard, and appears to have unintentionally and unfortunately resulted in speculation, uncertainty and chaos about when, and in what circumstances, the BAC would close.

Pre-August 2013 communications by WMHHS

281. Approximately three weeks later, WMHHS commenced the first of a series of 'Fast Facts' newsletters to BAC patients, families, staff and other child and youth mental health services in Queensland.[274]

282. The first Fast Facts, distributed on 13 November 2012,[275] asked the question, "Is Barrett Adolescent Centre Closing?" The response was "no final decision about a Barrett Adolescent Centre (BAC) has been made. Adolescents requiring longer term mental health care will continue to receive the care that is most appropriate for them". It was also said "a decision about Barrett Adolescent Centre will only be made once all recommendations from the clinical expert reference group have been considered".

283. On 20 November 2012, there was a meeting of the directors of adolescent inpatient units and the directors of major child and youth mental health services at the MHAODB.[276] Dr Sadler's evidence is that Ms Dwyer stated at this meeting that "there would be a period of review and development of alternative services that would occur prior to the closure of BAC and that it would not be closed by 31 December 2012."[277]

284. Fast Facts 2, dated 11 December 2012,[278] again assured that no decision about the future of the BAC had been made. With particular reference to the ECRG it was said "This was only the first meeting, so no recommendations or decisions have yet been made regarding Barrett Adolescent Centre". This Fast Facts posed the question, "Is it true that the Barrett Adolescent Centre will close regardless of the recommendations by the clinical expert reference group?" The response was "No final decision on Barrett Adolescent Centre has been made. What we are doing is investigating whether there are other models of care that can better meet the needs of Queensland adolescents who require longer term mental

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274 See Exhibit 100, Supplementary affidavit of Kerrie Parkin, 19 January 2016at Exhibit KP-3 [WMS.9000.0025.00001] at [.00018].

275 Exhibit 100, Supplementary affidavit of Kerrie Parkin, 19 January 2016 [WMS.9000.0025.00001] at [.00018] - Fast Facts 1.

276 Exhibit 112, Affidavit of Trevor Sadler, 11 December 2015, para 231 [DTZ.900.001.0001].

277 Exhibit 112, Affidavit of Trevor Sadler, 11 December 2015, para 231 [DTZ.900.001.0001].

278 Exhibit 100, Supplementary affidavit of Kerrie Parkin, 19 January 2016 [WMS.9000.0025.00001] at [.00020] - Fast Facts 2.

health treatment". This Fast Facts assured patients, families and staff that a decision about the BAC would not be made until recommendations from the clinical expert group had been considered.

285. The first Fast Facts for 2013[279] stated that the ECRG had not made any recommendations about the future of the BAC. Further, BAC patients, families and staff were assured that the decision would not be rushed, and:

> "*Before any decision is made, we want to determine if there is a better way we can meet the needs of Queensland adolescents who require longer term mental health care. All options for statewide models of care will be investigated by the Expert Clinical Reference Group. This may include partnerships with non-government organisations*".

286. In the second update for 2013 on 4 March 2013[280] it was again stated that no decision had been made about the future of the BAC, and that no decision would be made until after the ECRG had made its recommendations on the best model of care for Queensland's adolescents who require longer term mental health treatment.

287. By Fast Facts 5, issued on 21 May 2013,[281] patients, families and staff were told that the ECRG had met for the last time and had submitted seven recommendations to the overarching planning group. Again, assurances were made that no recommendations had been made about the future of the BAC and no decision would be made until all the recommendations of the ECRG had been carefully considered.

288. Fast Facts 6 was not issued until 23 August 2013, some 3 months later.

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279 Exhibit 100, Supplementary affidavit of Kerrie Parkin, 19 January 2016 [WMS.9000.0025.00001] at [.00022] - Fast Facts 3.

280 Exhibit 100, Supplementary affidavit of Kerrie Parkin, 19 January 2016 [WMS.9000.0025.00001] at [.00023] - Fast Facts 4.

281 Exhibit 100, Supplementary affidavit of Kerrie Parkin, 19 January 2016 [WMS.9000.0025.00001] at [.00024] - Fast Facts 5.

The "real" closure announcement

289. Dr Sadler's evidence is that on either 5 or 6 August 2013 he and Ms Clayworth met with Ms Dwyer and were told that the BAC would close in January or February 2014, utilising a "wrap around" model of care for existing patients.[282]

290. Shortly afterwards, staff and adolescents were then told of the intended closure. Dr Sadler sat in the office of Ms Kelly and rang each of the parents or carers of the patients. Dr Sadler recalls there was a rush to do this before the Minister's announcement was expected on ABC 612 that evening.[283]

291. said that shortly after received the phone call from WMHHS, heard the Minister's interview on ABC 612.[284]

292. In this radio interview on 6 August 2013, Minister Springborg publicly announced that the BAC would close. Fast Facts 6[285] refers to the Minister's announcement and states that adolescents requiring extended mental health treatment and rehabilitation would receive services through a new range of contemporary service options from early 2014. Other information given was "Young people receiving care from the Barrett Adolescent Centre (BAC) at that time will be supported to transition to other contemporary service options that best meet their individual needs". The final message was "There would be no gap to service provision for BAC patients".

293. No satisfactory explanation emerges from the evidence as to why, despite the numerous previous assurances, families, patients and staff were not provided with the promised updates and, indeed, were virtually given no notice that the BAC was to close.

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282 Exhibit 112, Affidavit of Trevor Sadler, 11 December 2015 [DTZ.900.001.0001] at [.0237].
283 Exhibit 112, Affidavit of Trevor Sadler, 11 December 2015, para 238 [DTZ.900.001.0001] at [.0050].
284 Exhibit 145, Affidavit of 10 February 2016, para 35 [FAM.900.013.0001].
285 Exhibit 100, Supplementary affidavit of Kerrie Parkin, 19 January 2016 [WMS.9000.0025.00001] at [.00025].

Understanding the lingo

294. The expressions "no gap in services" and "wrap around care" or "wrap around package" are littered throughout the evidence. It is instructive at this point to attempt to understand this language.

295. From a family's perspective, [redacted] evidence was that there was not a clear understanding of what wrap around services included. [redacted] identified, and the evidence reveals, that the view or understanding of wrap around services can vary widely.[286]

296. Professor McDermott described wrap around care as a confusing term that he tried not to use at all.[287] Dr Kingswell said that he does not think he ever used the term wrap around services and that he did not pretend to know what it meant.[288]

297. In his oral evidence Dr Groves states that there seemed to be a common group of [young] people who are not well served by acute units, not well served by community based services, and not well served by wrap around, however that is defined.[289]

298. Dr James Scott described the notion of wrap around care as "important".[290]

299. Ms Callaghan agreed that a wrap around package was an individualised package for each affected individual.[291]

300. Mr Eltham described wrap around as a generic term employed by a number of professionals and Government Departments to describe the suite of services tailored to individual needs of a patient greater than would have normally been provided by Community Mental Health Services as outpatient treatment.[292]

301. Dr Corbett described wrap around services as services provided that meet the individual needs of each patient.[293] Dr Corbett thought that there were additional services to provide

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[286] Transcript, [redacted] 8 March 2016, p 22-28 lines 5–11.
[287] Transcript, Brett McDermott, 16 February 2016, p 7-54 line 47; p 7-55 lines 1–3.
[288] Transcript, William Kingswell, 24 February 2016, p 13-79 lines 20–22.
[289] Transcript, Aaron Groves, 16 February 2016, p 7-82 lines 14–19.
[290] Transcript, James Scott, 17 February 2016, p 8-26 line 34.
[291] Transcript, Philip Hazell, 17 February 2016, p 8-66 lines 24–27.
[292] Transcript, Timothy Eltham, 18 February 2016, p 9-7 lines 15–35.
[293] Transcript, Mary Corbett, 18 February 2016, p 9-47 lines 1–3.

wrap around care such as the mobile outreach service, day programs, holiday program, and some acute beds.[294]

302. Ms Kelly was asked about the wrap around services available upon the closure of the BAC and described those wrap around services as an individualised service plan for each of the individual adolescents identified according to their needs.[295] Ms Kelly said, “It is about knowing what’s out there and wrapping that service around them and identifying where there is a gap, and then we were able to troubleshoot, I suppose, those gaps”.[296]

303. Dr Cleary combined the expressions when he said his focus was making sure wrap around care was in place for existing clients so that there was no gap in services for those young clients.[297] Dr Cleary went further to explain his view that there were two processes running parallel. The first he described as wrap around care for individual BAC patients for which there was a substantial body of work undertaken within the hospital and health service to put that wrap around care in place.[298] The parallel process was the development of the new services that were going to take some years which were the responsibility of Children’s Health Queensland.[299]

304. Dr Cleary’s understanding was that wrap around care included other services that would not normally be available, though not the new services being developed by Children’s Health Queensland.[300]

305. Dr Stathis said that the term wrap around services has a broad definition but essentially included the community, educational, mental health, vocational, housing and other services that may be wrapped around or pulled around young people to provide them with a platform of support, particularly in the community. These services included more than just mental health services. Dr Stathis identified that the complexity of the young peoples’ issues required a whole range of Government and Non-Government Organisations to “collaborate together to provide an adequate treatment plan”.[301] The

294 Transcript, Mary Corbett, 18 February 2016, p 9-51 lines 4–30.
295 Transcript, Sharon Kelly, 22 February 2016, p 11-18 lines l5–9.
296 Transcript, Sharon Kelly, 22 February 2016, p 11-18 lines 21–23.
297 Transcript, Michael Cleary, 25 February 2016, p 14-33 lines 32–33.
298 Transcript, Michael Cleary, 25 February 2016, p 14-33 lines 15–18.
299 Transcript, Michael Cleary, 25 February 2016, p 14-33 lines 28–33.
300 Transcript, Michael Cleary, 25 February 2016, p 14-34 lines 4–8.
301 Transcript, Stephen Stathis, 10 March 2016, p 24-58 lines 20–23.

responsibility for there being no gap in services was, according to Dr Stathis, a matter for WMHHS.[302]

306. The former Minister, Mr Springborg, gave evidence that, in the decision making process, the most critical thing was always patient care, that his role was not to advise on clinical decisions, and that his position was "I don't want any gap in services and I don't want any decisions made that are going to in any way adversely impact upon the care that we provide".[303]

307. The last word on this issue is best left with Dr Brennan, given that it was Dr Brennan who ultimately was left with the task to transition BAC patients to such care. She insightfully identified, as did that a number of people had used the term in all kinds of contexts. Dr Brennan's description of wrap around care is particularly useful and reliable. She says that wrap around care and the kind of care she hoped to provide for all young people was care across multiple domains which had been individualised and coordinated.[304]

<u>Treatment of BAC patients in 2012/2013 up to the real closure announcement</u>

308. In July and August 2012, Dr Sadler still believed that the BAC would be relocating to Redlands and was undertaking interviews with the view to employing more nursing staff.[305] When the Redlands project was deferred in August 2012, Dr Sadler's evidence is that he did not commence transition arrangements for the patients admitted to the BAC as it was unclear at that stage what was going to happen – he said that, at that stage, they had "no indication of what the future of the service could look like." [306] Dr Sadler's evidence is that there was a "continuing process of transition" during this period – that is, there would be "multiple stages in which there would be linkages with the community".[307]

309. Dr Sadler's evidence is that during this period until 6 August 2013, he believed that the BAC should "continue to work with adolescents in a way that it normally would with

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302 Transcript, Stephen Stathis, 10 March 2016, p 24-46 line 35.
303 Transcript, Lawrence Springborg, 26 February 2016, p 15-17 lines 15–17.
304 Transcript, Anne Brennan, 4 March 2016, p 20-67 lines 34–41.
305 Exhibit 112, Affidavit of Trevor Sadler, 11 December 2015, para 225 [DTZ.900.001.0001].
306 Transcript, Trevor Sadler, 9 March 2016, p 23-62 lines 28–29.
307 Transcript, Trevor Sadler, 9 March 2016, p 23-62 line 36.

regards to an orderly transition."[308] Vanessa Clayworth's evidence is that six patients were transitioned out of the BAC prior to the closure announcement in the ordinary course of their care.[309]

310. Dr Sadler's evidence is that the Minister's announcement on 6 August 2013 was the first time that he became aware that the BAC would not be moving to another location, that all the patients would be transitioned out and the BAC would be closed.[310] Dr Sadler's evidence is that Lesley Dwyer informed him and Vanessa Clayworth that the BAC would close in January or February 2014 utilising a "wrap-around model of care for existing patients".[311]

Transition clients identified

311. As a result of the closure or anticipated closure it was necessary to transition the BAC patients to alternative care arrangements. In Counsel Assisting's opening it was said that there were potentially 41 transition clients. This number was confined after the factual inquiry revealed that only AC patients had been transitioned in association with the closure or anticipated closure (whether before or after the closure announcement).

312. On 29 February 2016, a discussion table identifying the BAC patients identified by Counsel Assisting as falling within the Commission's Terms of Reference was provided to the legally represented parties.

313. A more detailed discussion of the adequacy of the transition arrangements for these transition clients is contained later in these submissions.[312]

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308 Exhibit 112, Affidavit of Trevor Sadler, 11 December 2015, para 249 [DTZ.900.001.0001].

309 Transcript, Vanessa Clayworth, 8 March 2016, p 22-51 lines 25–35; Confidential Note: These are see Transcript, Vanessa Clayworth, 8 March 2016, p 22-62 lines 25–35.

310 Transcript, Trevor Sadler, 9 March 2016, p 23-62 line 31.

311 Exhibit 112, Affidavit of Trevor Sadler, 11 December 2015, para 237 [DTZ.900.001.0001].

312 By Term of Reference 3(d)(i) the Commission must ascertain the facts associated with "how care, support, service quality and safety risks were identified, assessed, planned for, managed and implemented before and after the closure (i.e. the transition arrangements)" for these BAC patients. Further, the Term of Reference 3(h) requires the Commission (without limitation) to ascertain the facts associated with "the information, material, advice, processes, considerations and recommendations that related to or informed the transition arrangements".

Meaning of transition in mental health context

314. Before considering the alternative care arrangements for the transition clients, it is necessary to pause and consider the meaning of "transition" in the context of mental health.

315. The terms "transition", "transitioned", "transitional" and "transitioning" were used frequently in the evidence before the Commission. There was some differentiation in the evidence between the technical aspects (including assessment of clinical needs and planning for clinical care) and non-technical aspects (including the relationships between the clinicians and services and the young people, and the functionality in the multidisciplinary team that promotes good collaboration) of "transition".[313] However, the most widely cited definition of "transition" in the literature is:

> *"The purposeful, planned movement of adolescents and young adults with chronic physical and medical conditions from child-centred to adult orientated health care systems".*[314]

316. The transition of patients was an integral aspect of their care and management at the BAC whether back to their families or otherwise into the community, to another adolescent mental health service or, in some cases, to an adult mental health service. Transition in that sense appears to mean moving patients from one service to another for clinical reasons, based on individual patient assessments.

317. Both the evidence and the literature suggest that the period of transition is a known risk factor for mental health patients and can bring about periods of vulnerability.[315] For example, Ms Skippen's evidence is that young people frequently fall through the gaps during transition.[316] Ms Skippen said that the literature suggests that young people experiencing chronic health problems are more likely to engage in risky behaviours than

313 Exhibit 71, Statement of Beth Kotzé, 18 December 2015 [PBK.900.001.0001] at [.0020]-[.0021].

314 See for example Exhibit 117, Statement of Tania Skippen, 13 November 2015 [TSK.900.001.0001] at [.0017]; Exhibit 309, Blum, Garrell, Hodgman and Slap (.1993), Transition to Adult Health Care for Adolescents and Young Adults with Chronic Conditions Position Paper as referenced in Ipsos-Eureka Social Research Institute (.2008), Review of Transition of Young Adults Clinics, Final Report – Attachment 6: Literature Review [COI.012.0001.0009].

315 See for example, Exhibit 310, Western Australian Report of the Inquiry into Mental Health and Wellbeing of Children and Young People, Chapter 9 – Transition to Adulthood (2008) [COI.012.0001.0335].

316 See for example Exhibit 117; Statement of Tania Skippen, 13 November 2015 [TSK.900.001.0001] at [.0023].

their healthy peers during transition, and therefore have the potential for greater adverse health outcomes from these behaviours.[317] The Inter-district Transfer of Mental Health Consumers within South Queensland Health Service Districts Procedure ("the Inter-district Transfer Procedure"), which appears to be the Queensland Health procedure that applied to the patients transitioning out of the BAC following the closure announcement on 6 August 2013, also recognises that mental health consumers are at an increased risk of harm during periods of transition.[318]

318. The evidence also suggested that while there are differences between the meanings of the terms "transition" and "transfer", the terms can be used in mental health practice to mean the same thing.[319] For example, Associate Professor Beth Kotzé described the term "transition planning" as being used in everyday language as synonymous with discharge and transfer of care of young people irrespective of their age, between services or service components.[320] Ms Skippen differentiated between "transition" as a purposeful, planned movement of patients from one service to another, taking into account both developmental and illness-specific needs, and "transfer of care" as the transfer of professional responsibility and accountability for care of a mental health consumer to another person or professional or a combination of professionals. This differentiation in meaning between the two terms is supported by the *New South Wales Transfer of Care from Mental Health Inpatient Services – Standard Principles and Procedures 2012* document.[321] Ms Skippen notes that the term "transfer" is more service-focussed than encompassing broader patient-related aspects.[322]

319. Dr Brennan's evidence was that "transition" is a process, and it is not the same as "transfer", which she described as just a change at a point in time or discharge from one service followed by arriving at another service.[323] This view appears to be supported in

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317 Exhibit 312, New South Wales Agency for Clinical Innovation, Trapeze and the Sydney Children's Hospitals Network (2014), Key Principles for Transition of Young People from Paediatric to Adult Health Care [COI.012.0001.0405].

318 Exhibit 529, Procedure for Inter-District Transfer of Mental Health Consumers within South Queensland Health Service District dated July 2012 [MSS.002.012.0054].

319 Exhibit 118, Supplementary statement of Tania Skippen, 15 January 2016 [TSK.900.002.0001] at [.0025].

320 Exhibit 71, Statement of Beth Kotzé, 18 December 2015 [PBK.900.001.0001] at [.0003].

321 Exhibit 118, Supplementary statement of Tania Skippen, 15 January 2016 [TSK.900.002.0001] at [.0024]-[.0025].

322 Exhibit 118, Supplementary statement of Tania Skippen, 15 January 2016 [TSK.900.002.0001] at [.0025].

323 Transcript, Anne Brennan, 4 March 2016, p 20-16 line 15 – p 20-18 line 10. See also Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016 [DAB.001.0003.0001] at [.0036].

the literature. For example, Paul *et al* describe the difference between transitions and transfers in the following terms:

> *"Healthcare transition has been described as a purposeful, planned process that addresses the medical, psychosocial and education/vocational needs of adolescents and young adults with chronic physical and medical conditions as they move from child-centred to adult-orientated healthcare systems.*
>
> *Transfer is often discussed as a suboptimal version of transition but, in our hypothesis, it is distinct from transition and should be investigated alongside transition. Transfer is the termination of care by a children's healthcare provider and its re-establishment with an adult provider, i.e. more of an event or transaction between services. Transition is a process requiring therapeutic intent, which may be expressed by the young person's preparation for transition, a period of handover or joint care, transition planning meetings…and transfer of case notes or information summaries. Transition ultimately results in established engagement of the young person with adult services and therefore includes vital aspects of continuity of care".*[324]

<u>*Transition Period*</u>

320. The evidence was uncontroversial that there is no standard length of transition period and that there is a need to start transition planning as early as possible. For example, Ms Skippen's evidence was that transfer of care and/or discharge planning should start as soon as a patient is admitted to an inpatient mental health unit, as the purpose of admission is to provide mental health care and support so that the young person can return as soon as possible to living in the community with as little disruption to their life as possible.[325]

321. However, there was less consensus about when the transition period should end and in what circumstances it may be appropriate for shared care and cross tapering of services to occur. It appears to be a question of fact based on individual patient needs. For

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[324] Exhibit 311, Paul, M, Ford, T, Kramer, T, Islam, Z, Harley, K & Singh, S 2013, 'Transfers and transitions between child and adult mental health services', *The British Journal of Psychiatry,* 202, 36-40, DOI: 10.1192/bjp.bp.112.119198 [COI.012.0001.0365].

[325] Exhibit 118, Supplementary statement of Tania Skippen, 15 January 2016 [TSK.900.002.0001] at [.0010]-[.0011].

example, Dr Brennan described some transitions as requiring a gradual cross tapering of care, or parallel streams of care where in-reach is conducted into the receiving service. However, she also cautioned that other aspects of a patient's care would need to be clearly delineated into ending with the referring service and starting with a receiving service.[326] The evidence of Ms Skippen suggests that while a period of overlap of staff contact can support continuity of care, it is also possible that if a handover is extended for too long, it may restrict the receiving agency's ability to engage with the young person as their primary care provider.[327]

322. The Inter-district Transfer Procedure also emphasises that some transfers of consumer care may require a shared care arrangement for a period of time, and there was evidence that in some complex cases, interdigitating patients with a receiving service for a period of shared care was quite an established and well used principle.[328] However, Dr Sadler's oral evidence suggests that one of the most common transition procedures is for the transferring service to cease involvement in the patient's care, so as to make room for the receiving service to develop a therapeutic relationship with the patient.[329] Notwithstanding this, Dr Sadler did give evidence that cross tapering did occur at the BAC, with the BAC negotiating its level of involvement with the transitioning service so that everyone knew who had responsibility for the patient's care.[330] Dr Sadler also gave evidence that on rare occasions adolescents would be discharged from the BAC as inpatients or day patients, but continue as outpatients.[331] Ms Betson and Ms Northcote also gave evidence in support of cross tapering of services, in that a receiving service should work with a young person prior to their formal admission to allow time to engage with the service and get to know the care providers.[332]

323. In the context of the BAC transitions, Ms Skippen considered that the transition period was the time from which care was fully provided by the BAC through the period of shared engagement, to the time when care was fully provided by the receiving service.[333] This suggests that where a period of shared care or cross tapering of services is appropriate

326 Transcript, Anne Brennan, 4 March 2016, p 20-16 line 15 – p 20-18 line 10.
327 Exhibit 117, Statement of Tania Skippen, 13 November 2015 [TSK.900.001.0001] at [.0023].
328 Transcript, Brett McDermott, 16 February 2016, p 7-41 line 45 – p 7-43 line 2.
329 Transcript, Trevor Sadler, 1 March 2016, p 17-25 line 19.
330 Transcript, Trevor Sadler, 9 March 2016, p 23-61 line 30 – 23-62 ling 10.
331 Transcript, Trevor Sadler, 1 March 2016, p 17-25.
332 Transcript, Emma Betson, 7 March 2016, p 21-34.
333 Exhibit 118, Supplementary statement of Tania Skippen, 15 January 2016 [TSK.900.002.0001] at [.0010]-[.0011].

for an individual patient, the transition period may not end until such time as the period of shared engagement has ended.

Established transition guidelines 2012-2013

324. An analysis of the evidence suggests that established guidelines for transition planning, management and implementation were needed, but were lacking at the BAC, both in a general sense historically, and particularly with a focus on 2012-2013.[334] Dr Sadler's evidence, for example, confirms that there was no formal documentation about the transition process, and that this was in part due to the fact that each transition was an individual process which varied from patient-to-patient.[335] Ms Hayes and Ms Daniels gave evidence that there were no specific policies, procedures or statements of duties put in place for the transition coordination between 6 August 2013 and January 2014.[336]

325. During the health services investigation into the transition of patients from the BAC which was undertaken by Associate Professor Kotzé, Ms Skippen and Ms Geddes, WMHHS provided information to assist with the investigation. In response to a request by Ms Geddes for information and/or documents about the "business as usual" transition/discharge practice for the BAC (as articulated in formal policies and procedures), Ms Kelly enclosed the following documents:

> *"Attachment 7 – Procedure titled "Inter-district Transfer of Mental Health Consumers within South Queensland Health Service Districts" – This procedure was effective from 8 November 2010 until 12 May 2014 and describes the processes for managing the transfer of care of mental health consumers. Following the formation of Hospital and Health Services on 1 July 2012, this procedure continued to apply and be followed with all references to "Districts" being interpreted as referring to "Hospital and Health Services".*
>
> *Attachment 8 – Procedure titled "Inter-Hospital and Health Service Transition of Care of Mental Health Consumers from one Hospital and Health Service to another". This procedure replaced the procedure enclosed at Attachment 7,*

334 Transcript, Brett McDermott, 16 February 2016, p 7-41 line 45 – 7-23 line 2.
335 Exhibit 112, Affidavit of Trevor Sadler, 11 December 2015 [DTZ.900.001.0001] at [.0028]. See also Transcript, Trevor Sadler, 1 March 2016, p 17-24.
336 Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016 [WMS.9000.0029.00001]. See also Transcript, Carol Hughes, 3 March 2016, p 19-72 lines 8–28.

coming into effect on 13 May 2014 and reflects the transition to Hospital and Health Services.

Attachment 9 – Further extract from the document titled "The Barrett Adolescent Centre – Information for Parents and Carers". The extract provides a summary of discharge planning for patients admitted to the Centre.

Also, as referenced in Attachment 6, CIMHA is a key state wide tool supporting a range of clinical processes including discharge of patients and transition of care from one service to another".[337]

326. In this response, Ms Kelly also clarified that all staff at the BAC were expected to employ "business as usual" transition practice, policies and procedures as set out in these attachments for the transition of adolescents from the BAC between 6 August 2013 (when the closure of the BAC was announced) and January 2014. However, she also reiterates that the "business as usual" transition practices, policies and procedures were supplemented by "additional support from the West Moreton Management Committee, the Clinical Care Transition Panel and the Complex Care Review Panel".[338]

327. This conflicts with the relatively uncontroversial evidence regarding the nature of the transitions which occurred at the BAC following the closure announcement on 6 August 2013 compared with previous transitions. For example, during his interview with Associate Professor Kotzé and Ms Skippen on 13 October 2014, Mr Beswick, one of the Registered Nurses who worked at the BAC, described the transitions which occurred due to the closure as "totally different" to "business as usual" transitions.[339] Mr Sault, another Registered Nurse at the BAC, stated that:

"Prior to the closure decision, when a patient was being transitioned out of the BAC it was discussed by the multi-disciplinary team who had input into the transition planning and guided the transition process. The allocated care

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337 See Exhibit 319, Letter Sharon Kelly, West Moreton to Ms Kristi Geddes 19 September 2014 [COI.018.0002.9540] at [.9541]-[.9544].

338 See Exhibit 319, Letter Sharon Kelly, West Moreton to Ms Kristi Geddes dated 19 September 2014 [COI.018.0002.9540] at [.9541]-[.9544].

339 Exhibit 71, Statement of Beth Kotzé, 18 December 2015 [PBK.900.001.0001] at [.0355].

coordinator would usually have a greater role in the transition process. This did not occur after the closure decision was made".[340]

328. In his evidence, Professor McDermott described the closure of the BAC as an unprecedented and unusual circumstance which involved the emptying out of an entire facility and, as such, it required special consideration.[341] Following the health services investigation, Associate Professor Kotzé stated in oral evidence that the transitions which occurred at the BAC in 2013 were not "business as usual" in terms of the intensity of the process, the focus required and the timeframe, and she also questioned whether "business as usual" transitions at the BAC involved a focused or purposeful process.[342] It is therefore curious that a "business as usual" policy such as the Inter-district Transfer Procedure applied to the transitions that occurred following the closure announcement on 6 August 2013.

329. There is also the question of whether the Inter-district Transfer Procedure was an adequate procedure or policy in the context of the guidance it provided in relation to the transition of young people out of mental health services. The Inter-district Transfer Procedure sets out a number of transfer of care principles including the time it takes to complete, consistency with the consumers' recovery and that some transfers of consumers may require a shared care arrangement for a period of time.[343] The Inter-district Transfer Procedure also recognises that the transferring service must notify and preferably consult with the consumer's carers and family regarding the pending transfer of care.[344] In oral evidence, Associate Professor Kotzé stated that although the Inter-district Transfer Procedure, referred to as Attachment 7 in the letter from Ms Kelly, could not be described as "youth-friendly", it was an appropriate policy to guide transition discharge practice "in a general sense".[345] However, the report produced by Associate Professor Kotzé, Ms Skippen and Ms Geddes recommends that positive learnings in relation to good quality transitional planning be considered for distillation into the

340 Exhibit 722, Supplementary statement of Stephen Sault, 25 February 2016 [QNU.001.008.0046] at [.0065].
341 Transcript, Brett McDermott, 16 February 2016, p 7-41 line 45 – 7-43 line 2.
342 Transcript, Beth Kotzé, 9 March 2016, p 23-20 lines 35–45 – 23-21 line 5.
343 Exhibit 71, Statement of Beth Kotzé, 18 December 2015, Exhibit X [PBK.900.001.0001] at [.1570]-[.1580].
344 Exhibit 71, Statement of Beth Kotzé, 18 December 2015, Exhibit X [PBK.900.001.0001] at [.1570]-[.1580].
345 Transcript, Beth Kotzé, 9 March 2016, p 23-19.

development of a statement policy or review of the current transfer of care policy.[346] This suggests that the policy may not have provided sufficient age-specific guidance in the circumstances.

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

330. It is also uncontroversial that the Inter-district Transfer Procedure (or any other policies or procedures to assist with transition planning, management and implementation) were not made available to BAC staff. In oral evidence, Associate Professor Kotzé stated that, to the best of her recollection, none of the BAC clinicians or staff who were interviewed during the health services investigation mentioned the Inter-district Transfer Procedure.[347] This is supported in the evidence of a number of other BAC staff and clinicians including Ms Megan Hayes and Ms Carol Hughes, who stated that they were not aware of being referred to the Inter-district Transfer Procedure at the time.[348] Ms Hayes states that before a copy of the Inter-district Transfer Procedure was provided to her for the purposes of giving evidence before the Commission, she does not recall having seen it.[349] Mr McGrath gave evidence that he did not recall seeing the Inter-district Transfer Procedure before the Commission's oral hearings and that, when providing guidance to Ms Clayworth in relation to navigating her responsibilities, he did not refer her to any official policies or processes.[350]

331. There was also evidence that the resources which were made available to BAC staff to assist with transition planning, management and implementation were limited and not always kept up to date. For example, Ms Hughes and Dr Sadler gave evidence about the existence of a folder containing details of referring agencies and alternative services which was kept at the BAC nursing station, and a list of services that was maintained on a WMHHS shared drive.[351] However, Ms Hughes said that while some of this information was current and up to date, other things needed to be updated and there was often a need to research further information to supplement the broad statements about a

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346 Exhibit 71, Statement of Beth Kotzé, 18 December 2015 [PBK.900.001.0001] at [.0076].
347 Transcript, Beth Kotzé, 9 March 2016, p 23-19.
348 Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016 [WMS.9000.0029.00001]. See also Transcript, Carol Hughes, 3 March 2016, p 19-72 lines 8–28.
349 Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016 [WMS.9000.0029.00001].
350 Transcript, Padraig McGrath, 3 March 2016, p 19-2 line 25 – 19-3 line 15.
351 Transcript, Carol Hughes, 3 March 2016, p 19-72 lines 5–28. See also Exhibit 254, Third supplementary affidavit of Trevor Sadler, 26 February 2016 [DTZ.900.004.0001] at [.0003].

referring agency that were contained within the resource materials.[352] Dr Brennan expressed concern about the fact that the resources were far from comprehensive, not up to date, did not include accommodation providers and, in particular, did not contain details about adult services which, in her view, was relevant for the cohort who was being transitioned from the BAC. Dr Brennan recalls having to look up the details of referring agencies and alternative services in the white or yellow pages due to the limited resources which were available during the transition period.[353]

Transition after the "real" announcement under Dr Sadler

332. Even after the official announcement of the closure on 6 August 2013, Dr Sadler did not commence transition arrangements immediately after the closure announcement as there was "considerable upset amongst the adolescents" including "increase numbers of incidents" on the ward, and so staff were focused on stabilising the adolescents and managing those incidents.[354] This was confirmed by staff at the BAC.[355] Dr Sadler's evidence is that after the announcement of the closure, permanent staff left to seek employment elsewhere on account of the uncertainty of the future of the BAC.[356] BAC nurse Mr Beswick's evidence is that outgoing staff were replaced by staff who were less experienced in the area of adolescent mental health.[357]

333. BAC Psychologist, Ms Ashleigh Trinder, gave evidence that she observed that the loss of staff lead to a break in the adolescents' continuity of care:

> "*… as key staff were leaving, it created more distress. There was more themes of loss and abandonment. And so the idea or what I proposed was that retention [of staff] was key to ensure that there was stability, that therapy could continue as best*

352 Transcript, Carol Hughes, 3 March 2016, p 19-72 lines 5–28.

353 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016 [DAB.001.0003.0001] at [.0004]. See also Transcript, Anne Brennan, 4 March 2016, pp 20-8–20-9.

354 Transcript, Trevor Sadler, 9 March 2016, p 23-63 lines 31–32; see also Exhibit 254, Third supplementary affidavit of Trevor Sadler, 26 February 2016, paras 7 and 15 [DTZ.900.004.0001]; Exhibit 112, Affidavit of Trevor Sadler, 11 December 2015, para 239 [DTZ.900.001.0001].

355 Exhibit 103, Statement of Thomas Pettet, 4 December 2015, para 35 [DTP.900.001.0001] at [.0005].

356 Exhibit 112, Affidavit of Trevor Sadler, 11 December 2015, para 240(a) [DTZ.900.001.0001]; see also oral evidence of Sharon Kelly, 22 February 2016, p 11-38 lines 20–30; Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 15 [DAB.001.0001.0001]; oral evidence of Anne Brennan at Transcript, 4 March 2016, p 20-11 lines 20–30.

357 Transcript, Matthew Beswick, 29 February 2016, p 16-42 lines 5–10; see also oral evidence of Padraig McGrath, Transcript, 3 March 2016, p 19-4 lines 35–45, p 19-5 lines 5–30.

as possible under the circumstances and that there would be more resources should there be a closure."[358]

334. Ms Trinder also said that the uncertainty she faced regarding her employment contract affected her provision of individual therapy. She spoke of an "ethical battle" as to whether she should commence, terminate or hand over treatments, given that she did not have the certainty of her continued employment to ensure that she could continue to support the young people in her care.[359]

335. Dr Sadler's evidence is that:

> "*my thinking as to – to try to get the best wraparound service that we – we could and then to – to stabilise the – the adolescents to try to work with their mental health to get them as well as possible and then to look at what we needed to do in terms of accommodation and providing that support*".[360]

However, by the time Dr Sadler left the BAC in September 2013, Dr Sadler's evidence is that they were managing:

> "*quite high levels of unwellness, people on continuous observations, people who had attempted suicide, people who were becoming quite distressed and withdrawing from activities in which they were beginning to engage within the community*".[361]

336. Dr Brennan's evidence is consistent with Dr Sadler on this point. She says that there was intense distress in that the impending closure of the BAC had made many of the adolescents feel abandoned and that they were having everything taken away, to such an extent that in her early days she was predominately preoccupied with diffusing crises and stabilising young people.[362]

337. Dr Sadler says that at the time of the announcement of the closure, the only alternative services available for the BAC patients were acute inpatient beds and a possible day program on the North Side of Brisbane. He said that other community services such as

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358 Transcript, Ashleigh Trinder, 2 March 2016, p 18-27 lines 6–15.
359 Transcript, Ashleigh Trinder, 2 March 2016, p 18-26 lines 16–25.
360 Transcript, Trevor Sadler, 9 March 2016, p 23-63 lines 16–20; see also Exhibit 112, Affidavit of Trevor Sadler, 11 December 2015, para 250 [DTZ.900.001.0001].
361 Transcript, Trevor Sadler, 1 March 2016, p 17-26 lines 28–31.
362 Transcript, Anne Brennan, 4 March 2016, p 20-89 lines 42–47; p 20-90 lines 1–3.

CYMHS, community clinics and Headspace were not sufficient as stand-alone services for the BAC cohort.[363]

338. Dr Sadler explains that at the time of the announcement the SWAETRI was being established and he was a member of it, although the initial meeting was not held until 24 August 2013 because Ms Krause was overseas. Dr Sadler said it was planned that this group would establish working groups to facilitate the transition. These working groups were not established until 9 September 2013. Dr Sadler was on both the Services Option Implementation Working Group and the BAC Consumer Transition Working Group, which were not established until 9 September 2013. These groups, according to Dr Sadler, were intended to drive the transition process and develop the necessary new services.[364]

339. Dr Sadler says that it was really only on 9 September 2013 that it had become apparent to him that, at the time of the closure of the BAC, appropriate services would not be available for the adolescents.

340. Ms Kelly was unable to provide any examples of Dr Sadler being given oversight or support from WMHHS prior to Dr Brennan coming on board.[365] She agreed there were no weekly meetings with Dr Sadler. Ms Kelly's evidence is that neither the oversight committee nor BAC weekly update meetings were instituted until Dr Brennan arrived on 11 September 2013.[366] These meetings commenced when Dr Brennan started at the BAC because "we recognised we needed to provide her with some support".[367]

341. There is evidence of a plan by WMHHS, on or about 24 May 2013, to bring in a "senior clinician to support the transition and closure".[368] Ms Kelly's evidence is that this was to be Ms Clayworth.[369]

342. In particular, Ms Kelly's evidence is that they "put a senior nursing clinician to support the senior psychiatrist and … [bring] in an extra nurse unit manager behind to

363 Exhibit 254, Third supplementary affidavit of Trevor Sadler, 26 February 2016, para 2 [DTZ.900.004.0001].
364 Exhibit 254, Third supplementary affidavit of Trevor Sadler, 26 February 2016 [DTZ.900.004.0001].
365 Transcript, Sharon Kelly, 22 February 2016, p 11-39 lines 26–46.
366 Transcript, Sharon Kelly, 22 February 2016, p 11-39 lines 30–45; p 11-40 lines 10–15.
367 Transcript, Sharon Kelly, 22 February 2016, p 11-40 line 12.
368 Exhibit 746, Document entitled "*CONFIDENTIAL – WM HH Board Meeting 24 May 2013*" [WMS.0012.0001.19826].
369 Transcript, Sharon Kelly, 22 February 2016, p 11-40 lines 10–45.

operationally manage the unit so that there was one single senior nursing person able to support the psychiatrist moving forward."[370] The evidence is that this occurred well after May 2013. Ms Clayworth commenced in her role as Acting Clinical Nurse Consultant from 14 October 2013,[371] and Mr Bryce was brought in as a Nurse Unit Manager to relieve Ms Clayworth of her other duties so she could concentrate on the issues relating to transition.[372]

343. Dr Sadler's evidence is that he had no knowledge of the above plan.[373]

344. Under closer scrutiny, any criticism mounted against Dr Sadler about his lack of transition planning between the announcement and his being annot be maintained.

The handling of and impact of

345. Dr Brennan was appointed by WMHHS to act as clinical director of the BAC temporarily from 11 September 2013 to 30 January 2014,[374] after Dr Sadler was by Ms Dwyer [375]

346. Ms Kelly agreed that she and Ms Dwyer had a number of options open to them, including not [376] She says that an alternative role did not seem to be respectful to Dr Sadler given they did not have any openings commensurate with his qualifications.[377] Ms Kelly refers to Dr Sadler being unwell so it was an opportunity for him to take some time off. There is no evidence that this alleged "opportunity" was discussed with Dr Sadler at the time.[378]

370 Transcript, Sharon Kelly, 22 February 2016, p 11-40 line 20–30.
371 Exhibit 38, Affidavit of Vanessa Clayworth, 27 October 2015, para 4.1 [WMS.9000.0008.0001]; see oral evidence of Sharon Kelly, 22 February 2016, p 11-40 lines 20–25.
372 Transcript, Vanessa Clayworth, 8 March 2016, p 22-81 lines 20–37.
373 Transcript, Trevor Sadler, 1 March 2016, p 17-38 lines 11–22.
374 Although she remained employed by WMHHS until 9 March 2014; See Exhibit 28, Statement of Anne Brennan, 23 October 2015, paras 6 and 7 [DAB.001.0001.0001] at [.0003].
375 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015, paras 18.1–18.4 [WMS.9000.0010.00001] at [.00032].
376 Transcript, Sharon Kelly, 22 February 2016, p 11-45 line 26.
377 Transcript, Sharon Kelly, 22 February 2016, p 11-45 lines 35–38.
378 Transcript, Sharon Kelly, 22 February 2016, p 11-45 lines 16–24.

347. It is accepted that the legitimacy of Dr Sadler being by WMHHS is not within the scope of the Commission's Terms of Reference. The effect of Dr Sadler's being upon the transition process is relevant and is discussed in detail further below.

348. However the circumstances of Dr Sadler being are said to be made relevant to the Commission's Terms of Reference by Senior Counsel for WMHHS on the basis it was a matter relevant to a lack of clinical governance at the BAC. This is a somewhat curious approach to be advanced by WMHHS during the hearings for two reasons.

349. First, because there is no cogent evidence that a lack of clinical governance was an express reason for the closure of the BAC.

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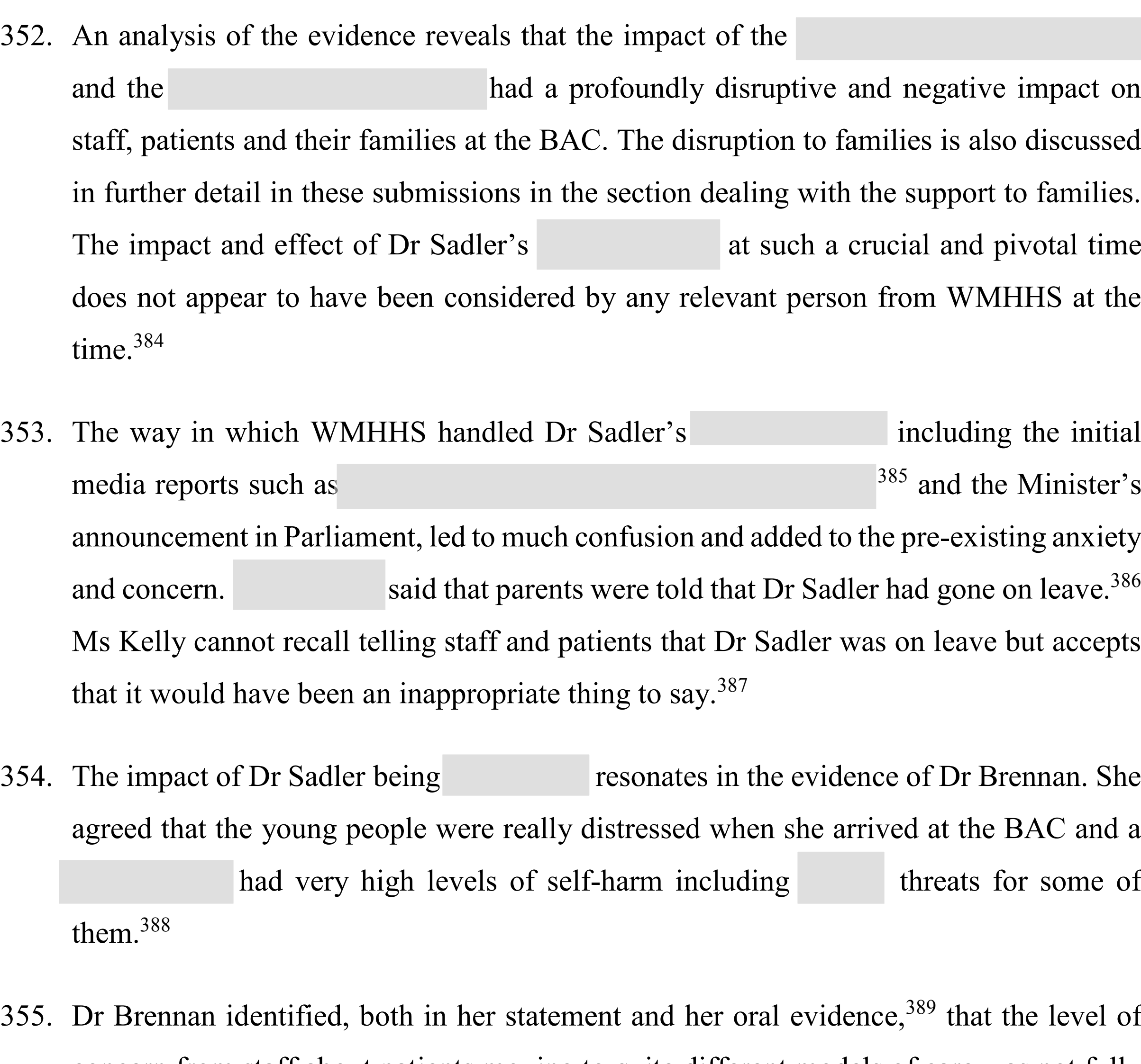
351. The relevance of this cross-examination is difficult to discern and not probative of any relevant issue given that it appears (and it was certainly not established) that the full extent of the allegations in the Investigation Report were not known to Ms Dwyer, Ms

379 Transcript, Sharon Kelly, 22 February 2016, p 11-52 line 39.

380 Exhibit 66, Statement of Sharon Kelly, 16 October 2015 at Exhibit SK-5 [WMS.9000.0006.00001] at [.00066]. Although see paragraph 25.2 at [.00034 See also Exhibit 30, Statement of Will Brennan, 16 November 2015, para 4.1 [WMS.9000.0013.00001] at [.00003].

381 Dr Sadler was not aware of this allegation at the time; Transcript, Stephen Stathis, 10 March 2016, p 24-13 line 38; Exhibit 55, Statement of Leanne Geppert, 16 October 2015, Exhibit LG-16 to that statement [WMS.9000.0004.00001] at [.00135].



Kelly or Dr Geppert[382] at the time Ms Dwyer [83] and certainly, at the time the decision to close the BAC was made.

The impact and effect of Dr Sadler's sudden departure.

352. An analysis of the evidence reveals that the impact of the and the had a profoundly disruptive and negative impact on staff, patients and their families at the BAC. The disruption to families is also discussed in further detail in these submissions in the section dealing with the support to families. The impact and effect of Dr Sadler's at such a crucial and pivotal time does not appear to have been considered by any relevant person from WMHHS at the time.[384]

353. The way in which WMHHS handled Dr Sadler's including the initial media reports such as [385] and the Minister's announcement in Parliament, led to much confusion and added to the pre-existing anxiety and concern. said that parents were told that Dr Sadler had gone on leave.[386] Ms Kelly cannot recall telling staff and patients that Dr Sadler was on leave but accepts that it would have been an inappropriate thing to say.[387]

354. The impact of Dr Sadler being resonates in the evidence of Dr Brennan. She agreed that the young people were really distressed when she arrived at the BAC and a had very high levels of self-harm including threats for some of them.[388]

355. Dr Brennan identified, both in her statement and her oral evidence,[389] that the level of concern from staff about patients moving to quite different models of care was not fully appreciated by Ms Dwyer, Ms Kelly and Ms Geppert. Dr Brennan also referred to nurses

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382 Exhibit 55, Statement of Leanne Geppert, 16 October 2015 at 22.1 to 22.6 [WMS.9000.0004.00001] at [.00036] - Dr Geppert knew from the ECRG and had received a phone call from her on 5 September 2013; Dr Geppert says she was not formally advised as to the reason for Dr Sadler being but understood it was pending an investigation into complaints by the and in the context that Dr Sadler intended to continue to treat

383 Exhibit 49, Statement of Lesley Dwyer, 6 November 2015 at 18.1 to 18.4 [WMS.9000.0010.00001].

384 Transcript, Anne Brennan, 4 March 2016, p 20-14 line 10.

385 Exhibit 145, Statement of 10 February 2016, para 40 and 41 [FAM.900.013.0001].

386 Transcript, 8 March 2016, p 22-18 line 38.

387 Transcript, Sharon Kelly, 22 February 2016, p 11-95 lines 22–34.

388 Transcript, Anne Brennan, 4 March 2016, p 20-89 lines 41–45.

389 Transcript, Anne Brennan, 4 March 2016, p 20-14 lines 1–6.

being traumatised as a result of their involvement in the investigation surrounding Dr Sadler being Insightfully, Dr Brennan identified that:[390]

> *"the nursing staff felt that their competence and commitment was under question and yet at the same time they were expected to continue to provide care for these adolescents who were dealing with a lot of anxiety and whose behaviour at times was very difficult to manage in a nursing setting. I – as I say, I don't know what more could have been done but I was aware that the nurses expressed a sense of being abandoned by the executive in terms of caring for their needs at that time."*

356. With reference to the of Dr Sadler, Dr Brennan says "I think the seed had been sown for them to feel vulnerable in a way they perhaps didn't need to".[391]

357. Dr Brennan said that the atmosphere of intense distress and uncertainty affected staff morale badly.[392] She described the atmosphere as "uncontained" and that there was "apprehension" and "anger". She said staff were struggling to cope with what had happened and the investigation into Dr Sadler, which involved several staff and care coordinators, was very threatening to staff.[393]

358. Professor McDermott was also able to identify the issue. Professor McDermott voiced concerns about how Dr Sadler's would have left staff (who were already chronically concerned about their jobs) feeling even more concerned about the patients. He identified that the patients and parents would have been even more distressed.[394]

359. There is no cogent evidence of Ms Dwyer, Ms Kelly and Ms Geppert having turned their individual (or group) minds to the effect that Dr Sadler's nd the subsequent investigation may have had on staff, patients, patients' families and indeed the transition process.

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390 Transcript, Anne Brennan, 4 March 2016, p 20-14 lines 19–25.
391 Transcript, Anne Brennan, 4 March 2016, p 20-22 lines 32–33.
392 Transcript, Anne Brennan, 4 March 2016, p 20-68 lines 1–8.
393 Transcript, Anne Brennan, 4 March 2016, p 20-68 lines 3–7.
394 Transcript, Brett McDermott, 16 February 2016, p 7-32 line 46 – 7-33 line 15.

Why no handover?

360. There is no satisfactory explanation as to why WMHHS did not orchestrate a handover between Dr Sadler and Dr Brennan.

361. Dr Brennan's evidence is that she was told by Dr Sadler that he would provide a written summary of each patient to Dr Neillie, and that Dr Neillie had confirmed this in a meeting in Ms Kelly's office.[395] Dr Neillie, in his supplementary statement,[396] says he knew about the written handover to Dr Brennan from an email he had received from Ms Kelly on 10 September 2013, but he could not recall whether this occurred.[397]

362. Dr Brennan subsequently tried to speak to Dr Hoehn and Dr Neillie about receiving a handover to no avail.[398] Dr Brennan said the major impediment to a handover was that the staff received a written direction that they were not to contact Dr Sadler. Importantly Dr Brennan said that a handover from Dr Sadler would have been of great assistance and that she had an expectation that she would receive such a handover.[399]

363. Whilst a handover between Dr Brennan and Dr Sadler was promised, it appears that no handover was allowed nor was one facilitated. Dr Brennan said she was prohibited from contacting Dr Sadler on the first morning she was at the BAC[400] (although she did so secretly - or opportunistically - on a couple of subsequent occasions).[401] Consistently with this evidence, Dr Sadler said he did not provide a formal handover to Dr Brennan because he was told by Ms Kelly when he was that he was to have no further input into the care of the adolescents at the BAC and the staff were instructed to not have contact with him.[402]

364. Ms Megan Hayes gave evidence that as far as she was aware, the instruction not to contact Dr Sadler still applied when the transition planning was underway and that it constrained

[395] Exhibit 28, Supplementary statement of Anne Brennan, 24 December 2015, para 9 [DAB.001.0003.0001].
[396] Exhibit 90, Supplementary statement of Darren Neillie, 23 October 2015, para 7.1 and 7.2 [WMS.9000.0026.00001].
[397] Exhibit 90, Supplementary statement of Darren Neillie, 23 October 2015 at Exhibit DWN-3 [WMS. 9000.0026.00001] at [.00015].
[398] Transcript, Anne Brennan, 4 March 2016, p 20-8 lines 30–34.
[399] Transcript, Anne Brennan, 4 March 2016, p 20-8 lines 11–15.
[400] Transcript, Anne Brennan, 4 March 2016, p 20-66 lines 36–38.
[401] Transcript, Anne Brennan, 4 March 2016, p 20-66 lines 43–45
[402] Exhibit 112, Affidavit of Trevor Sadler, 11 December 2015, para 257 [DTZ.900.001.0001] at [.0011].

the ability to facilitate the transition arrangements.[403] Ms Hayes went on to state that "Dr Trevor Sadler had a comprehensive knowledge of each adolescent's clinical presentation and had developed a therapeutic rapport which would have been invaluable to the transition process".[404]

365. Dr Brennan said that such a handover would, at the very least, have given her some insight and guidance as to the staff, resources and the patients. Her evidence is that Dr Sadler was an experienced psychiatrist and he knew the patient group very well, having been their sole psychiatrist for a number of years. She said that the most critical component of the handover would have been "a brief synopsis for each patient, but with, if I can say, a nuanced view of what their presentation and what their needs were?"[405] She would have also appreciated his view of staff and their skills, who to rely on, and any advice regarding potential "traps for new players".[406]

366. Ms Clayworth was able to provide a verbal handover. It is uncontroversial that she is a professional nurse who was held in high regard. Dr Brennan agreed that there was a verbal handover or explanation of each person from nurse Clayworth which she found very helpful.[407] However, the evidence from both Dr Sadler and Dr Brennan was that a handover between them would have been valuable. Dr Sadler said that he could have provided a synthesis and a longer term perspective on the issues.[408] Dr Brennan would have been assisted by an insight into each young person's psychopathology from a psychiatrist perspective as opposed to a skilled nurse.[409]

367. Dr Brennan states that had she been able to get a handover from Dr Sadler she would have requested a brief synopsis from him that had a nuanced view (meaning a short hand version of what's really going on for the young person).[410]

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403 Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016, para 15.1 [WMS.9000.0029.00001].
404 Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016, para 15.4 [WMS.9000.0029.00001].
405 Transcript, Anne Brennan, 4 March 2016, p 20-8 lines 20–24.
406 Transcript, Anne Brennan, 4 March 2016, p 20-8 line 26.
407 Transcript, Anne Brennan, 4 March 2016, p 20-81 line 36.
408 Transcript, Trevor Sadler, 9 March 2016, p 23-95 lines 5–22.
409 Transcript, Anne Brennan, 4 March 2016, p 20-89 lines 14–19.
411 Transcript, Anne Brennan, 4 March 2016, p 20-89 lines 39–40.

368. Whilst Dr Brennan was unsure, retrospectively, if a handover from Dr Sadler would have had any material impact on the transition for patients, she does say rather tellingly, "It might have made my work easier at the time".[411]

369. Given that the BAC was to close in the foreseeable future, that Dr Sadler had been the clinical director for a long time and that the young people involved in the incident that had led to his [redacted] were removed from the BAC almost immediately, two issues arise from the analysis of the facts. First, why was there not more consideration, planning, and communication about Dr Sadler's [redacted] with a view to minimising the impact and effect it was always obviously going to have on the patients who were to be transitioned out of the BAC.

370. Secondly, why was there not, at the very least, some handover facilitated between Dr Brennan and Dr Sadler. This ought to have been thought to be critical to an effective transition process.

371. Note that Dr Sadler's evidence is that "[i]f I had been given a similarly short time frame to work towards for the closure, I may well have come up with very similar transition plans. Having said this I would have felt compromised."[412] The evidence of Ms Clayworth is that she did not think it would have changed the places that the young people went because the decisions "went above the clinical director's role".[413]

<u>How were individual transition plans developed and implemented?</u>

372. Dr Brennan was not told that, on accepting the role as acting clinical director, she would be required to both devise and implement transition plans. She assumed from a number of conversations, including with those appointing her, that the transition process was already in place and her role would be to look after the young people until they had moved to new services.

373. When Dr Brennan took charge, it appears she was forced to go back to basics, including searching the telephone book, in order to locate services that may have been suitable to

[411] Transcript, Anne Brennan, 4 March 2016, p 20-89 lines 39–40.
[412] Exhibit 179, Supplementary affidavit of Trevor Sadler, 12 February 2016, para 70 [DTZ.900.002.0001] at [.0044].
[413] Transcript, Vanessa Clayworth, 8 March 2016, p 22-81 lines 44–45.

the young people she was required to transition. It appears that WMHHS did not appreciate the scale of the task, particularly as she was appointed on a part-time basis.[414]

374. The evidence shows that Dr Brennan cannot recall the details of each conversation she had upon or immediately before her appointment.[415] It is her evidence, however, that she was not told before, or upon, accepting the role that it would require her to devise and implement transition plans.[416] Moreover, Dr Brennan was appointed to the position on a part-time basis.[417] It seems WMHHS did not appreciate the scale of the task. Dr Brennan was not provided with a formal hand-over from Dr Sadler,[418] and it took several weeks to organise a computer for Dr Brennan.[419]

Clinical Care Transition Panel

375. In late September 2013, a panel called the BAC Clinical Care Transition Panel (‘the transition panel’), chaired by Dr Brennan with nominated BAC staff and WMHHS staff as members, was tasked with developing the individual transition plans.

376. Dr Brennan convened and chaired the transition panel and chose the staff who would be members on the basis of their skills and according to the needs of the patients.[420] Generally, the members of the transition panel included:[421]

(a) Ms Clayworth – A/CNC;

(b) Ms Hayes – OT;

(c) Ms Hughes – Social Worker;

(d) Ms Johnstone (nee Tooley) – administrative support;

(e) a standing invitation to a representative from the BAC School;

(f) Ms Daniels – Clinical Nurse;

414 Transcript, Anne Brennan, 4 March 2016, p 20-6 lines 12–13.
415 Exhibit 29, Statement of Anne Brennan, 27 January 2016, para 8 [DAB.001.0003.0001] at [.0007].
416 Exhibit 29, Statement of Anne Brennan, 27 January 2016, para 7 [DAB.001.0003.0001] at [.0006].
417 Transcript, Anne Brennan, 4 March 2016, p 20-6 lines 12–13.
418 Exhibit 29, Statement of Anne Brennan, 27 January 2016, para 9 [DAB.001.0003.0001] at [.0008].
419 Transcript, Anne Brennan, 4 March 2016, p 20-9 lines 35–36.
420 Exhibit 28, Statement of Anne Brennan, 23 October 2015 [DAB.001.0001.0001].
421 Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 39 [DAB.001.001.0001].

(g) a standing invitation to care coordinators;

(h) assistance from Ms Clarke – a speech pathologist; and

(i) on a case by case basis, carers, family members, and community service providers.

377. Ms Clayworth's evidence is that, in preparation for the commencement of transition planning, she implemented a 'range of processes'.[422] Consumer Care Review Summary and Plan templates were drawn up to provide a template for identifying and recording information. The evidence of Dr Brennan is that those templates did form the basis for consideration of the gamut of services each patient would require.[423] The templates themselves, however, are not necessarily a reliable guide to, or comprehensive record of, the extent of work done by the transition panel. Ms Clayworth's evidence is also that the templates were not complete.[424] It seems the administrative officer did not update the plans.

378. According to Dr Brennan, the function of the transition panel was to:

(a) explore the full range of possible care options for each individual young person;

(b) develop a list of options for each young person, and then to assist the care co-ordinator, young person, and their family to choose what best suited them. This was said to involve several hours of work every day, calling government and non-government agencies, attending meetings on and off-site, and preparing referral documents;

(c) make referrals, and communicate relevant matters to receiving services;

(d) where time permitted, trial services and monitor the transition; and

(e) keep WMHHS updated as to the progress of transition plans and transition care.[425]

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422 Exhibit 39, Supplementary statement of Vanessa Clayworth, 20 November 2015 [WMS.9000.0018.00001].

423 Transcript, Anne Brennan, 4 March 2016, p 20-19 lines 1–45.

424 Exhibit 39, Supplementary statement of Vanessa Clayworth, 20 November 2015, para 10.8 [WMS.9000.0018.00001].

425 Exhibit 28, Statement of Anne Brennan, 23 October 2015 [DAB.001.001.0001] at [.0011].

379. There is ample evidence that the transition panel explored the full range of possible care options for each individual young person.[426] This says nothing about whether the full range of possible (that is, existing) services were sufficient to meet the needs of the young people, or whether the risk of closing the BAC before replacement services were available was adequately managed by WMHHS, Children's Health Queensland, and Queensland Health more generally. That is considered below. Similarly, the evidence does not suggest that the receiving services were given anything less than adequate handovers.

380. As noted elsewhere in these submissions, it was Dr Brennan's evidence that for patients, there was sufficient time to approach the transition in a gradual way. Of the remaining patients, one was transferred to an acute unit and further transitional arrangements were not facilitated in any way by the BAC. The transition arrangements for patients, all of whom required long-term accommodation, were affected by the impending closure date and a lack of time. For of those patients, time was so critical that Dr Brennan did not characterise the arrangements as a 'transition', but rather as a 'transfer'. These patients are considered in more detail below.

381. A number of issues arise from this general overview.

First issue: What time frames were imposed for the closure of the BAC and were they reasonable for the transition arrangements?

382. Ms Hayes' evidence was that "there was a general sense of urgency to transition the adolescents from BAC during September 2013 - January 2014 which gained momentum once the closure date was announced". Ms Hayes could not recall when, during that time period, the closure date was announced.[427] As to whether the transitions had to be completed by a particular date, Ms Hayes' evidence was that "the target date changed over time depending upon the progress of the transitions".[428]

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426 See for example Exhibit 28, Statement of Anne Brennan, 23 October 2015 (and in general terms) paragraphs 43–70 and 76–109 [DAB.001.0001.0001]. And, in particular, Exhibit 39, Supplementary statement of Vanessa Clayworth, 20 November 2015 [WMS.9000.0018.00001] details extensively the work done to identify services.

427 Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016, para 5.7 [WMS.9000.0029.00001].

428 Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016, para 5.6 [WMS.9000.0029.00001].

383. As set out above, for the majority of the patients, the timeframe was reasonable and did not adversely affect their transitions to other services. For the patients requiring accommodation, however, a lack of time was a critical factor. The precise impact of the lack of time is considered in more detail elsewhere in the context of whether the transitions were 'adequate'.

384. There was evidence before the Commission that the closure date was "flexible". In reality, any flexibility proved illusory. Issues such as mix of the patients and a lack of appropriate staff made indefinite or further extended care under the guise of a "flexible closure date" difficult.[429] More critically, once the patients moved from the BAC, Dr Brennan formed a clinical view that it was unsafe to continue holding the patient at the BAC indefinitely until ideal options materialised.[430]

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

385. Ms Kelly's evidence was that the BAC's closure was not contingent upon the availability of a replacement model of service consisting of new services. Her evidence was that the closure was "…dependent on making sure that every adolescent that we had in our care at that particular point in time was provided with appropriate services moving forward."[431] If, however, appropriate services other than the BAC did not exist in the community for each individual young person, it follows that the absence of new, replacement services means the transition of the young people involved a higher risk than ought to have been assumed.

386. Ms Hayes' evidence was that "by around the time the Clinical Care Transition Panel (CCTP) meetings started, I knew that no 'new' service options would be available". She described that the lack of new or replacement services made the transition panel's task more difficult, as it was "necessary for CCTP members to allocate significant time to

429 Transcript, Anne Brennan, 4 March 2016, p 20-12 lines 33–43.
430 Transcript, Anne Brennan, 4 March 2016, p 20-44 lines 11–12.
431 Transcript, Sharon Kelly, 22 February 2016, p 11-18 line 1–3.

identifying appropriate services which could be combined to support the complex needs of the adolescents".[432]

387. The evidence suggests that the transition panel did escalate issues about the appropriateness of services for some young people to the WMHHS executive and beyond. For example, Dr Geppert's evidence was that:

> *"Were you aware that – whether Dr Brennan was reporting that she was having difficulties locating the services …---It was certainly a part of discussions in the weekly meetings.*
>
> *And were difficulties reported to – in these weekly meetings by Dr Brennan?---Yes.*
>
> *Was – the problems that Dr Brennan was reporting: were those problems about finding services to take these young people?---I think – I think that would be reasonable, to say that, in some occasions."*[433]

388. More particularly, Dr Geppert said:

> *many attempts at engaging with the relevant offices I believe at the clinical level for Dr Brennan, and despite those many attempts, Dr Brennan I believe was finding it very difficult to get traction and commitment around that opportunity being open to so Dr Brennan raised that several times. In the end, some of the strategies that we used were I would try our higher level within that department to raise the issue, see if we could actually address it more from a departmental perspective, and my recollection is that that didn't work successfully either, and that we were required then to write a briefing note into the Department of Health regarding our challenges with that particular barrier.*[434]
>
> *And to be clear about it, the problem was placing into a particular service?---Yes. The preferred service, based on his clinical need.*[435]

432 Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016, paras 5.1-5.3 [WMS.9000.0029.00001].
433 Transcript, Leanne Geppert, 19 February 2016, p 10-62 line 41 – 10-63 line 15.
434 Transcript, Leanne Geppert, 19 February 2016, p 10- 63 line 47 – 10-64 line 9.
435 Transcript, Leanne Geppert, 19 February 2016, p 10- 64 line 13.

I'm just very aware that there were barriers, and it wasn't progressing in a way that I believed Dr Brennan was happy with."[436]

389. In relation to [redacted] there was clear evidence that Dr Brennan formed a strong clinical opinion that the patient needed to transition to the [redacted] That did not occur. Dr Brennan accepted in her evidence that the transition plan was safe if additional nursing support was provided. However, this was Dr Brennan's "fall-back" option.[437]

390. There is no evidence that WMHHS gave consideration, at any stage, to ceasing or delaying the closure of the BAC in light of the concerns communicated to it by the transition panel. It appeared to be satisfied that if risk could be contained by measures (such as additional nursing support), then the transition arrangements were appropriate.

391. There is no convincing evidence that the closure of the BAC could not have been delayed until such time as replacement services were available. The existence of EFTRU is frequently cited in the evidence as a reason supporting the deadline for closure. The merits of that argument are discussed elsewhere. It suffices to say here that the existence of EFTRU does not appear to be a sufficient basis for failing to ensure replacement services were in place before the closure date.

392. It can fairly be said that to close a state-wide service for severely dysregulated and damaged adolescents without replacement services is odd. If the new services were being developed, it would be prudent to wait for their arrival before removing the support offered by the BAC. Dr Hoehn's evidence was that there was "…some urgency for Children's Health Queensland to ensure that new services for patients were up and running where possible prior to their transition from the Barrett Adolescent Centre."[438]

393. Associate Professor Kotzé said that if the suite of services were all up and running at the time it would have made no difference to the transition plans because of the bespoke nature of these individuals.[439]

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436 Transcript, Leanne Geppert, 19 February 2016, p 10-64 line 18.
437 Transcript, Anne Brennan, 4 March 2016, p 20-57 line 42.
438 Exhibit 64, Statement of Dr Elisabeth Hoehn, 18 November 2015, para 29 dated 18 November 2016 [CHS.900.001.0001].
439 Transcript, Beth Kotzé, 9 March 2016, p 23-56 lines 10–15.

394. Little, if any, weight ought to be afforded to Associate Professor Kotzé's evidence on this point. It is highly speculative and general. On her own evidence, she only looked in detail at six of the transition clients. Further, it does not take into account either the comorbidity of the transition clients nor some of their "dysfunctional" family backgrounds. Both of these issues are addressed later in these submissions.

395. An assessment of whether the risk to the patients was higher than ought to have been the case would require knowing, as at August 2013 to January 2014, what the new services were and which particular patients would have benefited from them, and in what way. That is a speculative exercise.

396. There is, however, an important broader point articulated by Dr Brennan:

> *"In the particular case of closing of the Barrett Centre, I think if there had been a shared narrative about why is Barrett closing it may have helped. It may have allayed some anxiety for some if there had been a clear understanding of when new services would come online and what would they be. And in particular, I think – as I understood it from the concerned consumers and their supporters, I think the perception that services weren't available was highly relevant. Whether those services in fact – and we can talk about this, perhaps, in different – in a closed session – whether those services, in fact, would have been appropriate services for particular young people is another issue. But the fact that some, particularly tier 3, were seen not to be available, I think, contributed to the perception of abandonment and I think that made the transition process very complex in this particular case. So it certainly wasn't business as usual."*[440]

397. This extract, too, explains the effect of the apparent uncertainty about the future of the BAC leading up to the closure. A lack of a "shared narrative" about why the BAC was closing contributed to creating the conditions in which rumour and undermining behaviour could flourish.

Third Issue: Impact of Dr Sadler being [redacted] on transition by Dr Brennan

398. Despite the abundance of evidence discussed elsewhere in these submissions in relation to the impact of Dr Sadler's [redacted] the evidence suggests that the actions of Dr

[440] Transcript, Anne Brennan, 4 March 2016, p 20-18 lines 1–12.

Brennan and other members of the transition panel mitigated that impact to a certain extent.[441] For example, Ms Hayes gave evidence that:

> "*Dr Brennan developed strong rapport with adolescents and families where possible and provided strong clinical leadership and reassurances to staff. The way in which Dr Brennan managed this change over reduced the potential negative impact of his absence*".[442]

The health services investigation which was undertaken by Associate Professor Kotzé, Ms Skippen and Ms Kristi Geddes reached a similar conclusion, in that:

> "*The process of transitional planning occurred in an atmosphere of crisis consequent to the announcement of the closure and th [redacted] of the senior leader of the service in the context of an unrelated matter, with escalation of distress in a number of the adolescents and staff of BAC. There appears to have been a contagion effect of distress and anxiety amongst the adolescents and an increase in incidents on the unit. However whilst the general atmosphere of crisis contributed to the complexity of the situation, it does not appear to have detrimentally affected the process of transitional care planning for the patients*".[443]

399. Associate Professor Beth Kotzé's written evidence confirmed that:

> "*the atmosphere of crisis was mitigated by the proactive clinical review and expert enactment of Clinical Care Plans for the effected consumers, the appointment of a senior clinical leader, that is Dr Brennan, who provided clear and personal leadership, the allocation of alternative duties to senior and experienced clinicians to enable them to focus on the transitional process and provide a sense of purposeful progression in care planning (that is, allocation of dedicated senior clinicians — for example, Ms Vanessa Clayworth), the communication strategy that included group and individual verbal and written communication to families and parents and the general strategies designed to*

441 Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016, para 15.5 [WMS.9000.0029.00001].

442 Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016, para 15.5 [WMS.9000.0029.00001].

443 Exhibit 71, Statement of Beth Kotzé, 18 December 2015 [PBK.900.001.0001] at [.0072].

manage the impact of change on the workforce, such as the provision of information in written and verbal form".[444]

<u>*Fourth issue: The impact (if any) of the lack of experienced and long-term BAC staff on the transition arrangements*</u>

400. Dr Brennan was concerned about the ability of agency staff to look after the patients at the BAC. This view was formed at least by December 2013. The evidence shows that:

    (a) one agency nurse was physically incapable of keeping pace with a patient leading to an emergency incident;

    (b) Dr Brennan held concerns that agency staff did not hold specific adolescent mental health experience; and

    (c) this, in turn, increased the burden placed on remaining staff with specific adolescent and mental health experience.[445]

401. There is also evidence from Mr Sault that:[446]

    (a) on two separate occasions, a nurse was rostered to the BAC after being removed from another area due to disciplinary issues;

    (b) one nurse was placed on reduced hours on morning shifts while allegedly being investigated for misconduct; and

    (c) another nurse was transferred from HSIS to the BAC following an incident at HSIS.

402. In Dr Brennan's oral evidence, she stated:[447]

    "So by mid-December you're saying that the guarantees that you'd been asking for about adequate nursing numbers and nurses not being rostered elsewhere at The Park and getting more support for nursing staff, you were content that that guarantee was followed through and you had adequate nursing support. Is that

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444 Exhibit 71, Statement of Beth Kotzé, 18 December 2015 [PBK.900.001.0001] at [.0021] to [.0022].
445 Exhibit 29, Statement of Anne Brennan, 27 January 2016, para 20 [DAB.001.0003.0001].
446 Exhibit 727, Supplementary statement of Stephen Sault [QNU.001.008.0046] at [.0051].
447 Transcript, Anne Brennan, 4 March 2016, p 20-12 lines 27–46.

your evidence, Dr Brennan? That is my evidence but may I add one more piece to that puzzle?

Yes, Dr Brennan? That is that right at the end when the numbers of patients were very small, there was a difficulty – and I am not sure that more numbers, more skills, was the answer. But the gender mix of the patients and the very small numbers made it difficult to roster adequate nursing staff in terms of, again, for them, gender and experience and being able to staff a ward which – usually, you needed two staff on a ward because even if there was only one patient, should there be an incident, one nurse was not enough. If you went on an outing, you really needed two nurses. So when the numbers of patients were very low, and I'm sure there's a formula that prescribes appropriateness in numbers to a particular number of patients, but it became a particularly difficult task to have adequate nursing when the numbers of patients were very low.

So at that point are you saying that you would've liked some more staff, some more nursing staff? Yes."

Fifth Issue: did the apparent breakdown in the relationship between the education staff and allied health and clinical staff have any impact on the transition arrangements.

403. Education staff viewed a healthy relationship with the health care team as being essential to an effective transition process.[448] The evidence is uncontroversial about an apparent breakdown in the relationship between education staff and allied health and clinical staff from late 2012. For example, Ms Nightingale gives evidence that:

"*There was a divide between health staff and education staff which became difficult to manage. This divide began festering from late 2012, when the Barrett Adolescent Centre staff first heard of the closure. The relationship between the education staff and health department staff deteriorated to the point where education staff was no longer welcome in the discussions about the closure, those meetings were for health staff only, and education staff were isolated. I believe one of the reasons for this was that education staff were more assertive in asking the Health department representatives questions about the future of the Barrett*

[448] Exhibit 96, Statement of Justine Oxenham, 24 November 2015 [JOX.900.001.0001] at [.0003].

Adolescent Centre, whereas the nursing staff felt bullied and intimidated and like they could not do anything".[449]

404. The evidence of BAC Psychologist, Ms Trinder, was that the "split" between the staff was exacerbated after Dr Sadler's departure, as he had been a "containing" figure who had brought the teams together.[450]

405. There was also evidence to suggest that a decision had been made by Ms Kelly to treat the education staff separately to the WMHHS clinical and nursing staff for the purposes of communications and consultations about the closure process and transition planning, though it is unclear to what extent this decision was communicated to other executive staff within WMHHS.[451]

406. In written evidence, Ms Nightingale also stated that (in her view) education staff were viewed as being obstructionist during the transition period and as a result, the nursing staff stopped communicating with them which in turn led to a feeling of isolation.[452]

407. The evidence on this topic suggests that there was no tangible detrimental effect on specific transition arrangements due to the relationship breakdown. The breakdown did, however, add to the burden under which the transition panel carried on their role of transitioning the patients from the BAC.

Transitioning under Dr Brennan

408. Dr Brennan's evidence is that "transition" is a process[453] which may include the following features:[454]

(a) an early start;

(b) be individual to patients (as distinct from generic);

(c) take account of the patient's wishes and best interests;

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449 Exhibit 91, Statement of Margaret Nightingale, 24 November 2015 [WIT.900.009.0001] at [.0009] to [.0010].
450 Transcript, Ashleigh Trinder, 2 March 2016, p 18-25 lines 33–42.
451 Transcript, Leanne Geppert, 19 February 2016, p 10-40 lines 5–30.
452 Exhibit 177, Supplementary statement of Margaret Nightingale, 9 February 2016 [WIT.900.018.0001] at [.0009].
453 Transcript, Anne Brennan, 4 March 2016, p 20-16 line 20 – 20-17 line 3.
454 Transcript, Anne Brennan, 4 March 2016, p 20-16 line 20 – 20-17 line 3.

(d) assessment of a range of services;

(e) communication with that range services;

(f) a gradual introduction to the selected service(s); and

(g) depending upon the particular issues faced by the patient, involve "parallel" or "cross-tapering" of care between the incumbent and receiving services(s).

409. Dr Brennan also agreed that transition would:[455]

(a) require detailed, careful, and lengthy communication with families;

(b) include early assessment of the available service options;

(c) include consultation as to the timing of replacement services; and

(d) involve skilled and consistent staff.

410. The matters immediately above are considered elsewhere in these submissions. It is enough to note here that the level of consultation with families was greater than usual. A depletion of experienced staff followed the announced closure of the BAC. Extensive consultation about timing of available services was possible, but pointless. No new services were available.

411. Dr Brennan said:[456]

> *And in terms of when it should start, I guess I had done – I had an interest, actually, in transition of adolescent to adult health care prior to ever going to Barrett, and I think it varies enormously, depending on the particular conditions. However, I think the guidelines around transition for adolescents or children to adolescent to adult services indicate that it really does need to start either at the point of admission into whatever service they're going to be leaving or very soon afterwards, and it certainly would need to have been in place, I think, for some months in this particular case.*

455 Transcript, Anne Brennan, 4 March 2016, p 20-17 lines 24–38.
456 Transcript, Anne Brennan, 4 March 2016, p 20-16 lines 34–41.

412. This evidence suggests that while 'transition' in this context may include generally applicable features, how those features apply alone and in combination will vary considerably from case to case. 'Transitions' are as individual as the patients to whom they apply.

413. The issue discussed here is whether the systemic or generally applicable features common to 'transitions' in this context were present in the transitions carried out by the transition panel.

414. But analysis of those factors cannot alone tell whether the transition was "business as usual". That is because the transitions occurred, in most cases, in order to allow the closure of the BAC and not due to clinical decisions in the ordinary course of patient care.

An early start?

415. Whether the start of the transition was 'early' is a relative question. A start is sufficiently early if there is time enough to carry out all of the steps required to complete the transition. Whether there is sufficient time is a question that can only be answered by reference to specific instances.

416. It was the common evidence of WMHHS executives and Directors of psychiatric services that the 6 months from August 2013 to January 2014 was sufficient time to effect an orderly transition.[457]

417. Dr Brennan's evidence was that for patients, the available time did not pose a barrier to parallel or "cross-tapered" care.[458] In her view, August 2013 was an early enough start to the transition for those patients.

ongoing arrangements for accommodation and mental health services were not arranged by the BAC.[459] The

457 See for example Exhibit 124, Statement of Terry Stedman, 16 October 2015, para 14.2 [WMS.9000.0005.00001].

458 Transcript, Anne Brennan, 4 March 2016, p 20-36 line 38 – 20-37 line 7

459 Transcript, Anne Brennan, 4 March 2016, p 20-60 lines 20–45 and p 20-61 lines 1–2.

remaining patients, for whom time was insufficient, have one feature in common: the need to find appropriate long-term accommodation as part of the transition plan.

Individual transition plans / Patient's best interests and wishes / Assessment of range of services

418. It is uncontroversial that the transition panel devised and implemented a transition plan for each individual patient. Similarly, a range of services were assessed by BAC staff, and patient's best interests and wishes were considered. It was not always possible, however, to accommodate those interests and wishes.

419. The result was that the transition plan as originally devised was not carried out.

420.

Gradual introduction and 'cross-tapering' of care

421. The importance of "cross-tapering" or parallel care was explained by Dr Brennan as follows. The passage also underscores the unusual nature of this transition, being that it

460 Exhibit 485, Statement of Dr Ian Williams, 9 March 2016 [MNH.900.0005.0001].

was carried out against the backdrop of the closure of the facility, rather than individual patient needs:[461]

> *"Yes. I think particularly for and potentially at that time but it changed, For them, it – I'm not sure that I would say they weren't prepared for transition. I think transition was always going to be difficult for them. And a longer timeframe would have assisted in providing, as you say, some in reach but having them ready. So, yes, maybe some more time to get them ready but more time also to not necessarily be involved in their care in their receiving service, but to be more like the past history, as I understand it from Barrett, which was the young person would transition to a new service and then could come back to Barrett and essentially complain about it but know that Barrett still existed.* ***Now, even if they didn't physically return and obtain support or interact with staff, the fact that Barrett existed, in their mind Barrett was still there, I think, is quite relevant. For these young people, they went to a new place. And in their mind, either immediately or very shortly after arriving there, Barrett didn't exist any more. And for them, they had lived there, that had been their world for sometimes a matter of years. And so for those particularly, I think that was relevant.***

[461] Transcript, Anne Brennan, 4 March 2016, p 20-37 line 30 – 20-38 line 15.

[Our emphasis added].

422. A lack of time was the critical issue affecting whether a “gradual introduction” or a “cross-tapering” of care was possible. The subsidiary issues involve whether the receiving service permitted parallel streams of care and, practically speaking, whether the BAC remained open after the patients transitioned from it.

423. The transitions for which time was an issue were

424. Dr Brennan characterised transition as a transfer, not a transition. A ‘transfer’ was said to be the point-in-time at which a patients transfers from one service to another. was the patient to leave the BAC. Virtually as did, it closed. No ‘cross-tapering’ of care was possible.

425.

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[462] Exhibit 29, Supplementary statement of Dr Anne Brennan, 27 January 2016 [DAB.001.0003.0001] at [.0026].

[463] Exhibit 29, Supplementary statement of Dr Anne Brennan, 27 January 2016 [DAB.001.0003.0001] at [.0028].

427. Except there was sufficient opportunity for a ‘cross-tapering’ of care.

Compliance with transition guides

428. Elsewhere in these submissions it is noted that Ms Geddes wrote to WMHHS during the Health Services Investigation to enquire whether ‘business as usual’ transition or discharge practices were articulated in formal policies and procedures. Ms Kelly’s response included the Inter-district Transfer document. A copy of such a document was put to Dr Brennan, Ms Clayworth, Dr Stedman, and Dr Hoehn. None of those witnesses had seen the document before preparing to give their evidence before the Commission. Given that the guides could fairly be characterised as generic or high-level, it is unlikely whether the guide shown to the witness would have provided particular assistance.

429. Otherwise, it seems that Dr Brennan was not provided with any relevant literature on the subject by WMHHS, or CHQ. Some literature was sent to her by a colleague, which she said was of little relevance.

Was there an urgency for the BAC to close?

430. Was the redevelopment of the Park Centre for Mental Health, specifically to include EFTRU, a reason to close the BAC urgently?

431. Dr Kingswell’s evidence is that EFTRU patients “would have unfettered access to the entire site, which included the BAC”. He said that the risk posed by EFTRU to the BAC patients was one “we could not afford to take”.[464]

432. With respect to the transition arrangements, the issue is whether the presence of EFTRU on The Park grounds caused, or justified, the timeframe within which the BAC was closed.

[464] Exhibit 68, Affidavit of Dr Kingswell, 21 October 2015, para 20 [DBK.900.001.0001].

433. Mr O'Sullivan QC cross examined Professor McGorry on the topic. The exchange is worth setting out in full:[465]

> *Now, were you told or are you aware of the specific modifications that were going on at The Park in relation to the care and rehabilitation of forensic patients during 2013? I might have been and – and that's my memory that there were some new developments in the forensic space there.*
>
> *Yes. To your recollection were you provided with an explanation of whether there was an assessment of the risk to the young adolescents by reason of the changes that were going on at The Park at the time? I don't think I was provided with detail about an objective assessment of risk to the – to the patients.*
>
> *I understand. I take it from that evidence that sitting here now you don't think that you had visibility over the details of what was going on at The Park in 2013 in terms of potential risk to the young people? Not – not in – not in sufficient detail.*
>
> *No? But – but I – but I suppose the impression I got from the discussions was that it was an appropriate thing to – to close – to try to close the unit for – perhaps for those – those sorts of reasons.*
>
> *I understand. When you provide your opinion to the learned Commissioner about it being irresponsible de-institutionalisation that's on the basis of your understanding of what was happening at the time as explained to you by Counsel Assisting? Yeah, yeah. If – if that proposition, as in the question, that the thing was closed before a replacement model of care had been finalised and implemented – if that – if that was the reality and, as you say, I've got no knowledge as to – to actually – whether it was the reality or not and I mean, that's probably – those are facts which are probably*
>
> *Outside your knowledge? fairly clear.*
>
> *Absolutely? But if that proposition is put, that – that would be responsible – irresponsible.*

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465 Transcript, Patrick McGorry, 2 March 2016, p 18-14 line 39 – 18-15 line 36.

Yes. If those were the only relevant factors, that would be your opinion? Yes.

Yes. I understand that. And if you were provided with new or different information about the risks that may have been present by reason of the redevelopments I imagine you might change your opinion? I don't think so because it's still the case that you've got to provide something that – that reduces risk before you remove something that's obviously

Absolutely. One is dealing ? putting a roof over people's heads.

isn't one, Professor, with risks and balancing risks in an appropriate and responsible way? Yes.

Yes? Yes. That's – that's – I agree with that.

434. Two propositions emerge from Professor McGorry's evidence:

(a) first, that to close the BAC before the alternative model of care was finalised and implemented is irresponsible; and

(b) second, that if there were "objective risks" to the patients, the risk should be balanced in an appropriate and responsible way.

435. There is evidence (which was not put to Professor McGorry) that WMHHS did balance that risk.

436. Dr Brennan's evidence was that when she assumed the position of A/Clinical Director of the BAC, she implemented a policy that no BAC patient should be allowed ground leave unless they were in sight of a staff member.[466]

437. Dr Stedman, who was directly involved in planning EFTRU, gave evidence that:[467]

"all of the people that have gone to EFTRU are people that could be managed readily in a community setting and pose no real risk to anybody anywhere so I – I think they're saying there that the – you know, a risk assessment was conducted

466 Transcript, Anne Brennan, 4 March 2016, p 20-10 lines 38–41.
467 Transcript, Terry Stedman, 3 March 2016, p 19-46 lines 11–22.

on each person so – and – and that they wouldn't have transferred to EFTRU if there was a – significant level of – of risk in any kind of setting – any domain.

Okay. So, Dr Stedman, am I right in thinking from that answer that the risk analysis was done individually for each patient who went to EFTRU - - -?---Yes.

- - - correct? And if that process detected that there was some risk, they wouldn't end up – that patient wouldn't end up at - - -?---Yes.

438. Dr Neillie was the Clinical Director of the High Secure Inpatient Service at The Park between November 2007 and July 2014.[468] His evidence is that he was "…heavily involved in the planning and development of EFTRU and when EFTRU first opened my responsibilities included clinical oversight of that service."[469]

439. Dr Neillie's evidence was that:[470]

   (a) there may have been a perception that there were risk implications for BAC patients in that EFTRU was a new service and the patient intake risk assessment procedure for EFTRU, whilst considered robust, was then untested;

   (b) in his opinion, the patient intake risk assessment procedures for EFTRU were robust;

   (c) the process for supervision of EFTRU patients designed for early identification of any deterioration in a patient's condition which might change their risk profile was robust;

   (d) while there may have been a perception that there were risk implications for BAC patients, those risks were the subject of a suitable risk management framework; and

   (e) even a robust risk assessment framework does not entirely remove risk.

440. It cannot be right that WMHHS, or the MHAODB, considered the risk of having the BAC patients and EFTRU patients on the Park grounds at the same time to be completely

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468 Exhibit 89, Statement of Darren Neillie, 23 October 2015, para 2.1 [WMS.9000.0001.00001].

469 Exhibit 89, Statement of Darren Neillie, 23 October 2015, para 2.4 [WMS.9000.0001.00001] at [.00002].

470 Exhibit 89, Statement of Darren Neillie, 23 October 2015, para 7.6 [WMS.9000.0001.00001] at [.00006] to [.00007].

unacceptable. That is because from August 2013, EFTRU opened and began receiving patients:[471]

> *"COMMISSIONER WILSON: Can I clarify one thing about EFTRU, you said it was scheduled to open in June or July?---2013. Yes.*
>
> *Yes. And you said you delayed the opening. It, in fact, opened in August, didn't it?---We started individually moving some patients in. Yes.*
>
> *And can you remember the approximate date in August?---No. I'm sorry. I can't remember the date.*
>
> *Was it around about 6 August?---I'm sorry. I don't know.*
>
> *I see. <u>But, anyway, the patients in the Barrett Adolescent Centre were progressively discharged between August and January?---That is correct.</u>*
>
> *<u>After EFTRU had opened?---Yes. And we progressively increased the cohort in EFTRU.</u>"* [Our emphasis added].

441. Ms Kelly's evidence was that while the risk may have been low, the consequence of it coming to pass were catastrophic.[472] So much may be accepted. But there is no evidence that any analysis was done to balance the risk calculus identified by Professor McGorry. That is, what was the appropriate balance between closing the BAC before the replacement model of care was finalised and implemented on the one hand; and on the other, allowing the BAC and EFTRU patients to be on the same grounds until the replacement model of care was finalised and implemented.

442. The only other issue which may be proffered as a basis for some urgency to close the BAC arises from the evidence of Dr Kingswell. When challenged on the absurdity of the evidence in his statement[473] that the clinical governance issue he saw [redacted] was one of the reasons for the closure of the BAC (announced on 6

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471 Transcript, Sharon Kelly, 22 February 2016, p 11-72 lines 25–40.
472 Transcript, Sharon Kelly, 22 February 2016, p 11-72 lines 15–20.
473 Exhibit 68, Affidavit of Dr William Kingswell, 21 October 2015, para 20(v) [DBK.900.001.0001].

August 2013) he backtracked and said, "It accelerated the need to close it and find alternative care for the young people that were resident in that facility".[474]

443. There is no suggestion in any of the evidence that the closure was accelerated because of concerns at the time (other than those of Dr Kingswell) about a lack of clinical governance. In any event the "culprit" (at least in Dr Kingswell's eyes) was almost immediately so any concern ought to have dissipated.

Coordination between transition and development of new services

444. It is uncontroversial that the responsibility for implementing the transitioning arrangements rested with WMHHS with oversight from its board, and that the development of the new range of contemporary services options was (and is) being led by Children's Health Queensland.

445. The evidence is that the BAC patients were transitioned to whatever services that were available at the time, rather than to a range of new, contemporary service options after the BAC closed.

446. Dr Sadler was initially a member of both the Service Options Implementation Working Group and the BAC Consumer Transition Working Group when these working groups were established on 9 September 2013. Dr Sadler's evidence is that his participation in these groups "was an essential platform for me to advocate for the adolescents at BAC. These groups were intended to drive the transition process and develop the necessary new services."[475] Dr Sadler also requested a position on the Financial and Workforce Planning Working Group in early September 2013. Dr Sadler's evidence is that:

> "*[t]his would have provided an even stronger platform to advocate for interim services, as well as funding for the development of other alternative services. Having said this, I was somewhat concerned that these three working groups had the potential to operate independently of one another.*"

474 Transcript, William Kingswell, 24 February 2016, p 13-4 lines 44–46.

475 Exhibit 254, Third supplementary affidavit of Trevor Sadler, 26 February 2016, para 3 [DTZ.900.004.0001].

However Dr Sadler's [redacted] took place prior to any meetings of any of these working groups.[476] Dr Sadler's evidence is that "Dr Brennan would have been unaware of my intentions to advocate for an interim service as a necessary part of transition."[477]

447. In a chain of correspondence between Dr Brennan, Dr Stathis, Dr Hoehn and Ingrid Adamson on 16 and 17 October 2013, Dr Brennan stated that "[i]n mid September Elisabeth and I decided that it was best to keep 2 separate streams going: I would be committed to care of current patients and Elisabeth and others would work on strategies for new models of care and development of such services." Dr Hoehn replied to this email stating "Anne is overwhelmingly busy managing BAC and the young people and I think we should keep to our original decision to have two parallel processes with me being the bridge between the two."[478] Further, Dr Brennan's evidence is that "there was significant distress on the part of several people connected with the Barrett and of some of the patients and their families about the provision of new services, the delay in providing them…I thought it best not [to] align myself in any way with a process that was causing [the patients and their families] distress."[479]

448. When Dr Stathis was questioned about the Project Plan for the State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy (SWAETRI), he insisted the Commission refer to the October 2013 version 1.1, which was approved by Dr Peter Steer, Chief Executive of Children's Health Queensland.[480] This version of the Project Plan lists the following objectives:

> *"[e]nsure continuity of care for adolescents currently admitted to BAC, and on the wait list through a supported discharge/ transition process to the most appropriate care option/s that suit individual consumer needs, and that are located in (or as near to) their local community".*[481]

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476 Exhibit 254, Third supplementary affidavit of Trevor Sadler, 26 February 2016, paras 5 and 6 [DTZ.900.004.0001].
477 Exhibit 254, Third supplementary affidavit of Trevor Sadler, 26 February 2016, para 15 [DTZ.900.004.0001].
478 Exhibit 777, Email correspondence between Dr Brennan, Dr Stathis, Dr Hoehn and Ingrid Adamson on 16 and 17 October 2013 [WMS.0018.0001.00510].
479 Transcript, Anne Brennan, 4 March 2016, p 20-21 lines 1–12.
480 Exhibit 300, Batch of documents from CHQ HHS including endorsed, SWAETRIS project plan and communications plan dated November 2013 [CHS.001.001.0741] at [.0773].
481 Exhibit 300, Batch of documents from CHQ HHS including endorsed, SWAETRIS project plan and communications plan dated November 2013 [CHS.001.001.0741] at [.0750].

449. While Dr Stathis agreed that Children's Health Queensland was responsible for the governance of the project, his evidence is that responsibility for the achievement of the above objective was devolved to WMHHS through the BAC Consumer Transition Working Group.[482] Dr Stathis' evidence is that developing services specifically for the BAC cohort was not "under the remit" of the Service Options Implementation Working Group,[483] whose task was "to build on the Expert Clinical Reference Group recommendations and develop preferred service options for adolescent mental health extended treatment and rehabilitation services."[484] However, Dr Steer's evidence is that Children's Health Queensland were:

> "*necessarily engaged on a number of levels understanding the progress around those transition plans…because we may have inherited some of those adolescents for ongoing care at transition, but also we did actually have to interface our planning of new services to the timing of the closure of Barrett eventually*"[485]

450. Dr Geppert's evidence is that the transition arrangements and the development of the new service options did not occur in isolation as WMHHS and Children's Health Queensland "communicated regularly around all relevant issues in both formal and informal forums".[486] Dr Geppert's evidence is that she sat on the SWAETRI Steering Committee and contributed in a "two-way direction, information from West Moreton and information from that committee back to West Moreton" and was, for example, in almost daily contact with Ms Adamson from Children's Health Queensland to consider correspondence.[487] Dr Geppert also identified Dr Hoehn, who attended the weekly BAC strategy meetings at WMHHS, as a "conduit…between the two HHSs".[488] Similarly, Ms Adamson's evidence was that "[t]he connection point was very much the interactions we would have and the advice that we would give each other at steering committee meetings"

[482] Transcript, Stephen Stathis, 10 March 2016, p 24-34 lines 1–30, p 24-37 lines 5–20; see also oral evidence of Ingrid Adamson, Transcript, 11 March 2016, p 25-47 lines 30–40; oral evidence of Lesley Dwyer, Transcript, 23 February 2016, p 12-106 lines 1–5; Exhibit 73, Supplementary affidavit of Judi Krause, 19 January 2016 [JKR.900.002.0001] at [.032]-[.033].

[483] Transcript, Stephen Stathis, 10 March 2016, p 24-37 lines 5–15, p 24-46 lines 10–20.

[484] Exhibit 122, Affidavit of Stephen Stathis, 5 November 2015, para 22 [DSS.001.001.001] at [.006].

[485] Transcript, Peter Steer, 10 March 2016, p 24-113 lines 10–20.

[486] Transcript, Leanne Geppert, 19 February 2016, p 10-33 lines 12–40; see also oral evidence of Stephen Stathis, Transcript, 10 March 2016, p 24-38 lines 1–40.

[487] See also Exhibit 14, Affidavit of Ingrid Adamson, 24 November 2015, paras 10-11 [IAD.900.001.0001] at [.0005].

[488] Transcript, Leanne Geppert, 19 February 2016, p 10-33 lines 5–40; see also oral evidence of Stephen Stathis, Transcript, 10 March 2016, p 24-38 lines 1–30.

and that "[t]he connection in terms of people was definitely Dr Gepeprt as she was on both working group 1 and working group 2."[489]

451. Even so, Dr Brennan's evidence is that she "did not know anything" about the availability of some longer term beds in the acute unit at the Mater Hospital in late 2013 or early 2014.[490] This is contrary to Dr Stathis' evidence, which is that he spoke about the subacute beds at a meeting of the Faculty of Child and Adolescent Psychiatry of the RANZCP Queensland on 26 November 2013, which Dr Brennan attended,[491] and that Dr Geppert and Dr Hoehn were aware that the subacute beds were being discussed with the Mater, and "could've cascaded that down to Anne as part of the whole process."[492] While Dr Stathis, Ms Adamson and Ms Dwyer were of the understanding that none of the BAC patients required a subacute bed,[493] Dr Brennan's evidence is that if she had known about the availability of a subacute bed, she could have considered this option for at least two young people.[494]

452. While Dr Brennan knew about the four-bed therapeutic residential service at Greenslopes operated by Aftercare,[495] Dr Geppert's evidence is that "some care was being taken" to ensure that no other BAC patients went to this service as there was f the BAC residing there, however she thought it "could have been reconsidered if needed."[496] Similarly, when questioned about this issue in relation to the subacute beds at the Mater Hospital, Professor McDermott's evidence was that if, hypothetically, Dr Brennan had contacted him about a bed at the Mater for another BAC patient while that former patient was admitted there, "[i]t wouldn't have been a blanket no but I would have

489 Transcript, Ingrid Adamson, 11 March 2016, p 25-47 lines 30–46.

490 Transcript, Anne Brennan, 4 March 2016, p 20-20 lines 1–10; see also Exhibit 359, Supplementary statement of Anne Brennan, 22 February 2016, para 11 [DAB.005.0001.0001] at [.0006].

491 Exhibit 281, Meeting Minutes of Faculty of Child and Adolescent Psychiatry of the RANZCP QLD dated 26 November 2013 [RAN.500.0001.0001]; see oral evidence of Stephen Stathis, Transcript, 10 March 2016, p 24-94 lines 40–45.

492 Transcript, Stephen Stathis, 10 March 2016, p 24-99 lines 5–10.

493 Oral evidence of Stephen Stathis, Transcript, 10 March 2016, p 24-48 lines 15–21; see also oral evidence of Lesley Dwyer, Transcript, 23 February 2016, p 12-99, lines 35–45; Exhibit 14, Affidavit of Ingrid Adamson, 24 November 2015, para 50 [IAD.900.001.0001] at [.0013]; oral evidence of Ingrid Adamson, Transcript, 11 March 2016, p 25-46 lines 35–47.

494 Transcript, Anne Brennan, 4 March 2016, p 20-79 line 20–45; see also Exhibit 359, Supplementary statement of Anne Brennan, 22 February 2016, para 12 [DAB.005.0001.0001] at [.0006]-[.0007].

495 Transcript, Anne Brennan, 4 March 2016, p 20-38 lines 34–36.

496 Transcript, Leanne Geppert, 19 February 2016, p 10-66 lines 1–5.

had a very detailed conversation about whether either party was being put in a place of danger."[497]

453. Senior Counsel for the State of Queensland brought Dr Stathis to the significant key risks to the SWAETRI project identified by the Project Plan, highlighting that the risks under the heading "Current Health Service Delivery" were the responsibility of WMHHS.[498] However, there are certain other risks listed in this section of the Plan as the responsibility of Children's Health Queensland which offer a different perspective. For example, the Plan clearly states that it was the responsibility of the Project Manager (that is – Children's Health Queensland) to manage the risk of "[c]ommunication gap between Working Groups, Committees and other forums" by acting as a "consistent conduit between all parties" and providing "[r]egular status updates to all parties".[499] Dr Brennan's evidence that she had no awareness of the availability of the subacute beds at the Mater hospital when she was transitioning the BAC patients indicates that this identified risk was realised and that the strategy of nominating "conduits" and "status updates" may have been a poor substitute for direct communication between the relevant parties.

454. Further, Children's Health Queensland was listed as responsible (along with the local Hospital and Health Service) for managing the risk of a "[c]ritical incident with an adolescent prior to availability of new or enhanced service options" by providing "[c]lear communication strategies with service providers regarding the development and rollout of service options" and "develop[ing] an escalation process for referral of consumers whose needs fall outside of existing service options."[500]

455. While it is not the role of the Commission to determine a causal link between any deficiencies in the management of this risk and any critical incident that occurred before the development and rollout of service options, there is evidence of certain deficiencies in communication and the development of an escalation process for consumers whose needs fell outside the existing service options.

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[497] Transcript, Brett McDermott, 16 February 2016, p 7-29 lines 32–37.
[498] Transcript, Stephen Stathis, 10 March 2016, p 24-107 lines 42–47, p 24-108 line 31.
[499] Exhibit 300, Batch of documents from CHQ HHS including endorsed, SWAETRIS project plan and communications plan dated November 2013 [CHS.001.001.0741] at [.0763].
[500] Exhibit 300, Batch of documents from CHQ HHS including endorsed, SWAETRIS project plan and communications plan dated November 2013 [CHS.001.001.0741] at [.0764].

456. Firstly, despite Dr Stathis' evidence that the subacute beds were available at the Mater Hospital from as early as November 2013 and at least from February 2014, Dr Brennan's evidence is that she was not aware of their existence and Dr Stathis himself had identified "communication to other Hospital and Health Services" as an "action needed to formalise the beds" as late as 10 March 2014 in a AMHETI Steering Committee meeting.[501] Dr Stathis' evidence in this regard is that the Hospital and Health Services "didn't need to know per se that the beds were available. What they did need to have is a clear line of communication to contact someone who might need a bed, and I was that person".[502] While Dr Stathis' asserts that Ms Kelly sent a memorandum to "all CEs and clinical directors of services across Queensland, stating that…if anyone required a subacute bed, they should contact me", on Dr Stathis' own evidence, Ms Kelly sent this memorandum in October 2013 before the Mater Hospital arrangement was negotiated (in November 2013).[503] Indeed, the memorandum itself merely states that Children's Health Queensland had commenced work on the future model of adolescent extended treatment and rehabilitation services and to contact Dr Stathis to discuss any clinical issues for patients who require these services in the meantime.[504] Similarly, the minutes of the meeting of the Faculty of Child and Adolescent Psychiatry of the RANZCP Queensland on 26 November 2013, at which Dr Stathis purports to have spoken about the subacute beds, merely record that Dr Stathis provided an update about "[p]lans for extended treatment and rehabilitation services from West Moreton funding" including a "Bed based sub-acute unit".[505]

457. Secondly, in a chain of email correspondence between Dr Brennan Dr Geppert and Dr Stathis from 13 to 20 February 2014,[506] in response to Dr Brennan identifying that "[t]here are who may have 'slipped through the cracks'", Dr Stathis responds, stating that "[w]e are unable to offer increased service at this time; they would need to be followed up at their local CYMHS or other appropriate local services." Dr

501 Exhibit 122, Affidavit of Stephen Stathis, 5 November 2015, Exhibit N to that statement, Minutes of AMHETI Steering Committee dated 10 March 2014) [DSS.001.001.001] at [.233].

502 Transcript, Stephen Stathis, 10 March 2016, p 24-102 lines 35–37.

503 Transcript, Stephen Stathis, 10 March 2016, p 24-48 lines 38–41.

504 Exhibit 284, Memorandum from Sharon Kelly to Executive Directors and Clinical Directors, Mental Health Services dated 22 October 2013 [WMS.1007.0038.0001].

505 Exhibit 281, Meeting Minutes of Faculty of Child and Adolescent Psychiatry of the RANZCP QLD dated 26 November 2013 [RAN.500.0001.0001]; see oral evidence of Stephen Stathis, Transcript, 10 March 2016, p 24-94 lines 1–45.

506 Exhibit 122, Affidavit of Stephen Stathis, 5 November 2015, Exhibit V to that statement, Emails between Dr Brennan, Dr Geppert and Dr Stathis from 13–20 February 2014 [DSS.001.001.001] at [.405].

Stathis' evidence is that this sentence should be read as Children's Health Queensland being unable to offer services (other than those that these patients might have been receiving in the private sector) on the basis that these patients were not current patients, or living in the catchment, of Children's Health Queensland. His evidence is that "[g]iven that these were patients on the waitlist, and it was West Moreton HHS' responsibility to manage the waitlist, I requested that Dr Anne Brennan, as A/Clinical Director of BAC, offer re-assessment or broker engagement with their local CYMHS." [507] The evidence is that Dr Brennan did in fact do this.[508] Despite Dr Steer's evidence that "after the closure of Barrett there was a transfer of the operational governance and responsibilities for ongoing services to Children's Health Queensland",[509] Dr Stathis' evidence is that "Children's Health Queensland is not going to accept the clinical responsibility of ex-Barrett clients or patients that have been transferred out of their catchment area. That's not how the system works. But we did hold funding and we could assist other hospital and health services in terms of further support for young people, and, indeed we did."[510]

Adequacy of transition arrangements

458. The expression "adequacy" has the Oxford Dictionary meaning of sufficient or satisfactory.

459. On Tuesday 8 March 2016, Counsel Assisting provided an Interpretation Note of the Terms of Reference (TOR) relating to transition clients. This Interpretation Note identified that the inquiry into the adequacy of transition arrangements required by TOR 3(d)(ii) includes a consideration of the adequacy of the capacity of the receiving service and the type of service provided to the transition clients, but does not extend to an inquiry directed to the adequacy or quality of the actual provision of the alternative care service itself, or clinical outcomes of the treatment at the alternative care services.

460. Under TOR 3(e) however, the task is expressly stated to be an inquiry into the adequacy of the care, support and services that were provided to transition clients. As set out in the

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507 Exhibit 123, Supplementary affidavit of Stephen Stathis, 5 November 2015, para 82 [DSS.001.002.001] at [.028].

508 Exhibit 123, Supplementary affidavit of Stephen Stathis, 5 November 2015, para 82 [DSS.002.001.001] at [.028]; Exhibit 122, Affidavit of Stephen Stathis, 5 November 2015 at Exhibit V [DSS.001.001.001] at [.405] (Emails between Dr Brennan Dr Geppert and Dr Stathis from 13 to 20 February 2014).

509 Transcript, Stephen Stathis, 10 March 2016, p 24-115 lines 1–11.

510 Transcript, Stephen Stathis, 10 March 2016, p 24-44 lines 31–35.

Interpretation Note, this does not call for an open-ended inquiry. The focus does include a qualitative assessment of the care, support and services that were actually provided, limited in the temporal sense identified in the draft transition client table circulated to the parties on 29 February 2016.

461. Despite the overriding theme revealed above (that the transition arrangements were carried out amidst a backdrop of extraordinary and heightened emotions that reached a crescendo at the time of the announcement of the closure), the balance of the evidence tends to the conclusion that Dr Brennan and her team worked tirelessly in extraordinarily difficult circumstance in an attempt to transition 16 transition clients to existing services.

462. On 11 March 2016, profiles of the 16 transition clients were made available to the represented parties in the data room.

BAC Cohort

463. Before considering these arrangements it is useful to reflect upon what the evidence tells us about the young people who have been variously described as the BAC cohort.

464. Counsel Assisting understand that there may be a suggestion that the BAC cohort did not have severe and complex mental health conditions. Counsel Assisting understand further that it is uncontroversial that the degree of disability is related to severity and acuity, which are separate concepts but often overlap. Severity and acuity can be related to diagnosis and if there are multiple diagnoses, then this is often referred to as complex. This fits with language used in the evidence of Dr Brennan, Dr Sadler and Associate Professor Kotzé (which is outlined below), when describing the BAC cohort.

465. Dr Trevor Sadler's evidence was that the BAC cohort:

> *"Had previously received a range of less restrictive interventions with specialist services in adolescent mental health, but still had persisting symptoms of their mental illness and consequent functional and developmental impairments; and*
>
> *Were likely to benefit from the range of clinical interventions ranging from day patient admission to an inpatient admission".*[511]

[511] Exhibit 112, Affidavit of Trevor Sadler, 11 December 2015 [DTZ.900.001.0001] at [.0010] to [.0011].

466. In particular, Dr Sadler gives evidence that:

> "*the predominant disorders with which young people presented to BAC were severe and persistent:*
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> *(a) depression with dissociated self-harm and depression;*
>
> *(b) anxiety, especially social anxiety disorder;*
>
> *(c) Post-Traumatic Stress Disorder (**PTSD**);*
>
> *(d) eating disorders, both anorexia nervosa and bulimia nervosa; and*
>
> *(e) severe psychotic disorders".*[512]

467. In Counsel Assisting's opening, it was noted that young people were accessing or trying to access the BAC at the time the closure was announced. Of these young people, were admitted to the BAC meaning that were never admitted. On review of the diagnostic profiles at the BAC, schizophrenia, anorexia nervosa, oppositional defiant disorder and autistic spectrum disorder were much less prevalent at the BAC than complex post-traumatic stress disorder social anxiety disorder and depression .[513]

468. Dr Brennan stated in oral evidence "that the concept that the diagnosis conveys the degree of disability or informed the service that you would need is (not)[514] inadequate. I think the diagnosis – certain diagnoses are often associated with a range of impairments and, as I said, consequent disability".[515] Professor McGorry also reiterates in oral evidence that "severity comes from an accumulation of multiple problems, not just from a specific diagnosis".[516]

469. Ms Trinder's evidence was also that:

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[512] Exhibit 112, Affidavit of Trevor Sadler, 11 December 2015 [DTZ.900.001.0001] at [.0010] to [.0011].

[513] Counsel Assisting acknowledges that the clinical records for only have been tendered into evidence based on identification as 'transition patients'.

[514] Counsel Assisting have assumed that the word "not" is missing on the basis that it is inconsistent with her next statement.

[515] Transcript, Anne Brennan, 4 March 2016, p 20-32 lines 42–45

[516] Transcript, Patrick McGorry, 2 March 2016, p 18-10 lines 30–31.

"*As a professional who has worked both at the Barrett Centre and now at headspace, can you explain briefly to the Commission any differences, if there are any, and how you approach individual therapy at headspace as compared to how you approached the individual therapy at the Barrett Centre? Well, I guess they're very different populations of adolescents that I'm dealing with now than what I did work with at the Barrett Centre. I guess at headspace it's typically for early intervention for clients with mild to moderate mental health issues, and at the Barrett Centre, obviously, it was severe and complex*".[517]

470. During the health services investigation which examined the adequacy and appropriateness of the transitional arrangements, Associate Professor Kotzé found that "in a number of instances the young people had psychiatric disorders that on their own, did not cross the threshold to service in the community mental health system".[518] This was clarified in oral evidence by Associate Professor Kotzé when she stated that the BAC cohort was a "population where no one service element in a contemporary system is going to fit because you have particularly difficult and complex patients with a trajectory already in train".[519] Associate Professor Kotzé also gave the following evidence during oral hearings:

"Given what you learned during the investigation, would you – do you accept that a number of the Barrett Centre patients had – presented with very complex and complicated conditions? Yes.

And a number of them, from what you had been provided, had already exhausted treatment options within the community? Yes.

And did you accept that these patients did not readily fit within service systems or cross the threshold to service in the community mental health system? Yes.[520]"

471. In light of this evidence, any argument that the BAC cohort was not a group of young people with complex and severe mental illness seems difficult to maintain.

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517 Transcript, Ashleigh Trinder, 2 March 2016, p 18-24 lines 31–38.
518 Exhibit 71, Statement of Beth Kotzé, 18 December 2015 [PBK.900.001.0001] at [.0074].
519 Transcript, Beth Kotzé, 9 March 2016, p 23-55 lines 18–20.
520 Transcript, Beth Kotzé, 9 March 2016, p 23-13 lines 33–41.

472. Further, the evidence contains many references to comorbidity. In medicine, the strict definition of the term comorbidity[521] refers to the diagnosis of one or more diseases in addition to a primary disease. In psychiatry the term refers to the coincidence of two or more psychiatric disorders. Using the strict definition, the following transition clients can be said to have comorbid disorders or manifested "comorbidity".

473. It is also instructive at this point to consider the impact having a child with a serious mental health condition has on families and carers. A review of the former Barrett patients that Counsel Assisting have been able to obtain some evidence about insofar as their family circumstances are concerned (all of the transition clients and

[521] American Psychiatrist Association (2013): Diagnostic and Statistical Manual of Mental Disorders. 5th Edition. Arlington, VA: American Psychiatric Association.

statements from parents of patients who were not transition clients) reveals that families could be described as coming from challenging family environments. This expression is used in the context that having a child with serious mental health conditions has caused a breakdown of the family structure and placed an inordinate amount of stress on the families, often to the extent that it is not possible for the adolescent to live at home.

Were the transition arrangements of the transition clients adequate?

Overview of transition arrangements

474. As noted elsewhere in these submissions, it was Dr Brennan's evidence that fo patients there was sufficient time to approach the transition in a gradual way. Of the remaining patients, was transferred to an acute unit and further transitional arrangements were not made by the BAC. The transition arrangements for patients, all of whom required long-term accommodation, were affected by a lack of time. For of those patients, time was so critical that Dr Brennan did not characterise the arrangements as a 'transition', but rather as a 'transfer'. At this point in the submissions, we review the accommodation, clinical care and educational or employment arrangements of those patients about which there appear to be no significant issues.

Accommodation

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[522] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 123 [DAB.001.0001.0001] at [.0046] to [.0047].

[523] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 124 [DAB.001.0001.0001] at [.0047] to [.0048]; Exhibit 453, Statement of 22 February 2016, para 11 [FAM.900.0017.0001] at [.0002].

[524] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 125 [DAB.001.0001.0001] at [.0047] to [.0049]; Exhibit 454 Statement of 24 February 2016 [FAM.900.018.0001].

[525] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 126 [DAB.001.0001.0001] at [.0049] to [.0051]; Exhibit 328, Patient Summary of para 36 [COI.026.0001.0062 at .0068], citing Exhibit 188, Statement of 6 February 2016 [WIT.900.024.0001] at [.0005].

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[526] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 118 [DAB.001.0001.0001] at [.0039] to [.0040]; Exhibit 331, Patient Summary of para 24a [COI.026.0001.0085] at [.0089], citing Exhibit 882, BAC clinical records [WMS.2002.0001.02132] at [.02172].

[527] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 120 [DAB.001.0001.0001] at [.0041]-[.0044]. medical records, however, indicate he may have been a day patient for up to four months: Exhibit 332, Patient Summary of [COI.026.0001.0129].

[528] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 119 [DAB.001.0001.0001] at [.0040]-[.0041].

[529] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 117 [DAB.001.0001.0001] at [.0037]-[.0038].

[530] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 115 [DAB.001.0001.0001] at [.0037]-[.0038]; Exhibit 333, Patient Summary of para 21 [COI.026.0001.0157] at [.0161], citing Exhibit 598, Clinical Records [QHD.001.003.7746] at [.7828].

[531] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 121 [DAB.001.0001.0001] at [.0044]-[.0045]; Exhibit 325, Patient Summary of paras 33-35 [COI.026.0001.0028] at [.0035].

[532] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 115(d) [DAB.001.0001.0001] at [.0032]-[.0034]; Exhibit 330, Patient Summary of para 33 [COI.026.0001.0075] at [.0081].

[533] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 126 [DAB.001.0001.0001] at [.0049]-[.0051]; Exhibit 188, Statement of 16 February 2016, para 28 [WIT.900.024.0001] at [.0005]; Transcript, Anne Brennan, 4 March 2016, p 20-83.

[534] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 125 [DAB.001.0001.0001] at [.0047]-[.0049]; Exhibit 454 Statement of dated 24 February 2016 [FAM.900.018.0001].

[535] Exhibit 454 Statement of dated 24 February 2016, para 23 [FAM.900.018.0001] at [.0004].

[536] Exhibit 329, Patient Summary of para 13 [COI.026.0001.0070 at .0072]; Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 117 [DAB.001.0001.0001] at [.0037]-[.0038].

[537] Exhibit 333, Patient Summary of para 21 [COI.026.0001.0157] at [.0161], citing Exhibit 598, Clinical Records [QHD.001.003.7746] at [.7828].

477.

Clinical Care

478. For their clinical care, in general, the patients were referred to a combination of CYMHS, Headspace or Open Minds, and private psychologists or psychiatrist. A few were admitted to hospital shortly after leaving the BAC, and others engaged with additional specific services.

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538 Cross-examination of Trevor Sadler by Ms McMillan, Transcript, 1 March 2016, p 17-82 lines 1–15; Cross-examination of Anne Brennan by Ms Muir, Transcript, 4 March 2016, p 20-83 lines 25–47; Cross-examination of Vanessa Clayworth by Mr Freeburn, Transcript, 8 March 2016, p 22-79 lines 4–14.

539 Exhibit 327, Patient Summary of para 40 [COI.026.0001.0046] at [.0055]

540 Cross-examination of Anne Brennan by Ms Muir, Transcript, 4 March 2016, p 20-60 lines 13–15; Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 123 [DAB.001.0001.0001] at [.0046] to [.0047].

541 Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 123 [DAB.001.0001.0001] at [.0046] to [.0047]. para 45 [COI.026.0001.0010] at [.0019], citing Exhibit 465, Summary - Appendix 4 Mater Involvement with MHS.001.005.1211].

542 Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 117 [DAB.001.0001.0001] at [.0037] to [.0038]; Exhibit 329, Patient Summary of para 23 [COI.026.0001.0070] at [.0074]; Exhibit 149, Statement of 19 January 2016, para 54-55 [WIT.900.010.0001] at [.0011].

543 Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 121 [DAB.001.0001.0001] at [.0044] to [.0045]; Exhibit 325, Patient Summary of para 39 [COI.026.0001.0028] at [.0036].

544 Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 115 [DAB.001.0001.0001] at [.0035 to .0036]; Exhibit 333, Patient Summary of para 24 [COI.026.0001.0157 at .0161], citing Exhibit 891, Confidential Medical Records, Volume 3 [WMS.2002.0001.05904] at [.05906].

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545 Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 120 [DAB.001.0001.0001] at [.0041]-[.0044]. so after to attend Exhibit 332, paras 21 and 24 [COI.026.0001.0129] at [.0133 to .0134].

546 Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 118 [DAB.001.0001.0001] at [.0039 to .0040]; Exhibit 331, Patient Summary of para 27 [COI.026.0001.0085] at [.0089], citing Clinical Notes [QHD.001.003.5705]; Exhibit 154, Statement of 5 February 2016, paras 38 and 44 [FAM.900.009.0001] at [.0005]-[.0006].

547 Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 123 [DAB.001.0001.0001] at [.0046 to .0047]; Exhibit 324, Patient Summary of para 45 [COI.026.0001.0010] at [.0019], citing Exhibit 465, Summary - Appendix 4 Mater Involvement with [MHS.001.005.1211].

548 Exhibit 325, Patient Summary of para 38 [COI.026.0001.0028] at [.0036], citing Exhibit 876, BAC Clinical Records [WMS.2002.0001.00001] at [.00075].

549 Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 117 [DAB.001.0001.0001] at [.0037]-[.0038].

550 Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 124 [DAB.001.0001.0001] at [.0047 to .0048]; Exhibit 326, Patient Summary of paras 28-30 [COI.026.0001.0039] at [.0042]-[.0043], citing Exhibit 293 Email [ACA.001.0001.0011] and Exhibit 526, BAC Progress Notes [MSS.002.005.0250] at [.0351]; Exhibit 453, Statement of ated 22 February 2016, para 27 [FAM.900.0017.0001] at [.0005].

551 Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 126 [DAB.001.0001.0001] at [.0049 to .0051]; Exhibit 328, Patient Summary of s 31 and 40 [COI.026.0001.0062] at [.0068], citing Exhibit 188, Statement of 16 February 2016 [WIT.900.024.0001] at [.0005].

552 Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 118 [DAB.001.0001.0001] at [.0039 to .0040]; Exhibit 327, Patient Summary of para 48 [COI.026.0001.0046] at [.0056].

553 Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 115 [DAB.001.0001.0001] at [.0035 to .0036]; Exhibit 333, Patient Summary of para 22 [COI.026.0001.0157] at [.0161], citing Exhibit 891, Confidential Medical Records, Volume 3 [WMS.2002.0001.05904] at [.05906].

554 Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 126 [DAB.001.0001.0001] at [.0049 to .0051]; Exhibit 328, Patient Summary of paras 32–33 [COI.026.0001.0062] at [.0067 to .0068]; Exhibit 188, Statement of 6 February 2016, para 30 [WIT.900.024.0001] at [.0005].

555 Exhibit 154, Statement of 5 February 2016, para 44 [FAM.900.009.0001] at [.0006]; see also Exhibit 331, para 27 [COI.026.0001.0085] at [.0089].

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[556] Exhibit 323, Patient Summary of para 42 [COI.026.0001.0001] at [.0008], citing Exhibit 129, Witness Statement of Ashleigh Trinder, 30 October 2015, para 7.19 [WMS.9000.0011.00001] at [.00008]. arranged this independently as it could not be part of transition plan given Ms Trinder was still a Queensland Health employee: Cross-examination of Ashleigh Trinder by Ms Muir, Transcript, 2 March 2016, p 18-32 line 31 – p 18-33 line 15. It should be noted that there is a lack of clarity about whether or not the BAC was able to arrange for Ashleigh Trinder to see for example, see: Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 125 [DAB.001.0001.0001] at [.0048]-[.0049].

[557] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 125 [DAB.001.0001.0001] at [.0048]-[.0049].

[558] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 117 [DAB.001.0001.0001] at [.0037]-[.0038].

[559] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 115(f) [DAB.001.0001.0001] at [.0035 to .0036]; Exhibit 333, Patient para 33 [COI.026.0001.0157] at [.0162], citing Exhibit 891, Confidential Medical Records, Volume 3 [WMS.2002.0001.05904] at [.05954]".

[560] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 124 [DAB.001.0001.0001] at [.0047 to .0048]; Exhibit 326, Patient Summary of para 27 [COI.026.0001.0039] at [.0042]. Exhibit 453, Statement of dated 22 February 2016, para 28 [FAM.900.0017.0001] at [.0005].

[561] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 120 [DAB.001.0001.0001] at [.0041]-[.0044]; Exhibit 332, Patient Summary of paras 34–37 [COI.026.0001.0129] at [.0135].

[562] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 118 [DAB.001.0001.0001] at [.0039]-[.0040].

[563] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 115(d) [DAB.001.0001.0001] at [.0032 to .0034]; Exhibit 330, Patient Summary of para 37 [COI.026.0001.0075] at [.0081].

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564 Some patients were referred to GPs, but it is unclear whether they attended, for example: (Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 126 [DAB.001.0001.0001] at [.0049 to .0051]; Exhibit 328, Patient Summary of para 29 [COI.026.0001.0001] at [.0062]); and (Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 117 [DAB.001.0001.0001] at [.0037]-[.0038]).

565 Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 125 [DAB.001.0001.0001] at [.0048]-[.0049].

566 Exhibit 325, Patient Summary of para 36 [COI.026.0001.0028] at [.0035]-[.0036]; Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 121 [DAB.001.0001.0001] at [.0044]-[.0045].

567 Dr Susan Byth, UQ Healthcare: Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 115(d) [DAB.001.0001.0001] at [.0032]-[.0034], Exhibit 330, Patient Summary o 3 October 2015, para 35 [COI.026.0001.0075] at [.0081], citing Exhibit 884, BAC Medical Records [WMS.2002.0001.02541] at [.02584]-[.02588].

568 Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 117 [DAB.001.0001.0001] at [.0037]-[.0038]; Exhibit 149, Statement of 9 January 2016, paras 52–53 [WIT.900.010.0001] at [.0011].

569 Exhibit 330, Patient Summary of para 38 [COI.026.0001.0075 at .0081], citing Exhibit 884, BAC Medical Records [WMS.2002.0001.02541] at [.02606]-[.02608].

570 Exhibit 326, Patient Summary of paras 48 [COI.0026.0001.0039 at .0044], citing Exhibit 528 [MSS.002.012.0050] at [.0052] and Exhibit 526 [MSS.002.005.0250] at [.0404]; Exhibit 453, Statement of dated 22 February 2016, para 26 [FAM.900.017.0001] at [.0005],

571 Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 115(d) [DAB.001.0001.0001] at [.0032 to .0034]; Exhibit 330, Patient Summary of para 36 [COI.026.0001.0075] at [.0081], citing Exhibit 884, BAC Medical Records [WMS.2002.0001.02541] at [.02599]-[.02601].

572 Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 118 [DAB.001.0001.0001] at [.0039]-[.0040].

573 Cross-examination of Anne Brennan by Ms Muir, Transcript, 4 March 2016, p 20-36 line 43 – p 20-37 line 7.

Education / Employment

486. In terms of education and employment, appear to have continued their education, continued employment and one focused on developing life skills.

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[574] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 117 [DAB.001.0001.0001] at [.0037]-[.0038]; Exhibit 329, para 23 [COI.026.0001.0070] at [.0074]; Exhibit 149, Statement of 19 January 2016, paras 54–55 [WIT.900.010.0001] at [.0011].

[575] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 118 [DAB.001.0001.0001] at [.0039 to .0040]; Exhibit 331, Patient Summary of para 27 [COI.026.0001.0085] at [.0089], citing Exhibit 589 [QHD.001.003.5705]; Exhibit 154, Statement of , 5 February 2016, paras 38 and 44 [FAM.900.009.0001] at [.0005] and [.0006].

[576] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 126 [DAB.001.0001.0001] at [.0049 to .0051]; Exhibit 328, Patient Summary of as 31 and 40 [COI.026.0001.0062] at [.0068], citing Exhibit 188, Statement of 16 February 2016 [WIT.900.024.0001] at [.0005],

[577] Exhibit 327, Patient Summary of para 48 [COI.026.0001.0046] at [.0056] and Exhibit 600, Progress Note [QHD.001.003.8396] at [.8607].

[578] Exhibit 327, Patient Summary of ara 48 [COI.026.0001.0046] at [.0056].

[579] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 125 [DAB.001.0001.0001] at [.0048]-[.0049].

[580] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 124 [DAB.001.0001.0001] at [.0047]-[.0048]; Exhibit 326, Patient Summary of paras 28–30 [COI.0026.0001.0039] at [.0042]-[.0043], citing Exhibit 339 [DAB.004.0001.1356] and Exhibit 347 [DAB.004.0001.3816]; Exhibit 453, Statement of 22 February 2016, para 27 [FAM.900.017.0001] at [.0005].

[581] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 123 [DAB.001.0001.0001] at [.0046]-[.0047]. 2014: exhibit 324 [COI.026.0001.0010]-[.0020] citing Exhibit 617 [QHD.002.002.9431].

[582] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 120 [DAB.001.0001.0001] at [.0041]-[.0044].

[583] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 118 [DAB.001.0001.0001] at [.0039]-[.0040]; Exhibit 331, para 26 [COI.026.0001.0085] at [.0089], citing Exhibit 489[MSS.001.001.0017; Exhibit 154, Statement of 5 February 2016, para 40 [FAM.900.009.0001] at [.0005].

[584] Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 118 [DAB.001.0001.0001] at [.0039]-[.0040].

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585 Exhibit 330, Patient Summary of para 28 [COI.026.0001.0075] at [.0080].

586 Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 115 [DAB.001.0001.0001] at [.0035 to .0036]; Exhibit 333, Patient Summary of para 22 [COI.026.0001.0157] at [.0161], citing Exhibit 891 [WMS.2002.0001.05904] at [.05906].

587 Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 124 [DAB.001.0001.0001] at [.0047]-[.0048]; Exhibit 326, Patient Summary of paras 33–37 [COI.0026.0001.0039] at [.0043]; Exhibit 453, Statement of 22 February 2016, paras 18 and 25 [FAM.900.017.0001] at [.0004] and [.0005].

588 Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 126 [DAB.001.0001.0001] at [.0049 to .0051]; Exhibit 328, Patient Summary of 34 [COI.026.0001.0001] at [.0068], citing Exhibit 860, Community Contacts undated [WMS.1006.0116.00021].

589 Exhibit 325, Patient Summary of para 40 [COI.026.0001.0028] at [.0036] and [.0037].

590 Exhibit 323, Patient Summary of para 14 [COI.026.0001.0001] at [.0003], citing [FAM.900.018.0001] at [.0003]"; Exhibit 454, 24 February 2016, para 30 [FAM.900.018.0001] at [.0005].

591 dated 24 February 2016, paras 30 and 32 [FAM.900.018.0001] at [.0005].

592 Exhibit 329, Patient Summary of para 16 [COI.026.0001.0070] at [.0073], citing WIT.900.010.0001] at [.0008[40]"; Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 117 [DAB.001.0001.0001] at [.0037]-[.0038].

593 Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 115 [DAB.001.0001.0001] at [.0035 to .0036]; Exhibit 333, Patient Summary of para 37 [COI.026.0001.0157] at [.0163], Exhibit 169, Statement of 15 December 2015, para 33 [WIT.900.015.0001] at [.0006]

594 Exhibit 453, Statement of 22 February 2016, para 18 [FAM.900.0017.0001] at [.0004].

595 Exhibit 453, Statement of 22 February 2016, paras 18 and 25 [FAM.900.0017.0001] at [.0004] and [.0005].

490. Although the majority of the transition arrangements appear to be adequate, Dr Brennan raised concerns about patients. These patients are considered in detail below.

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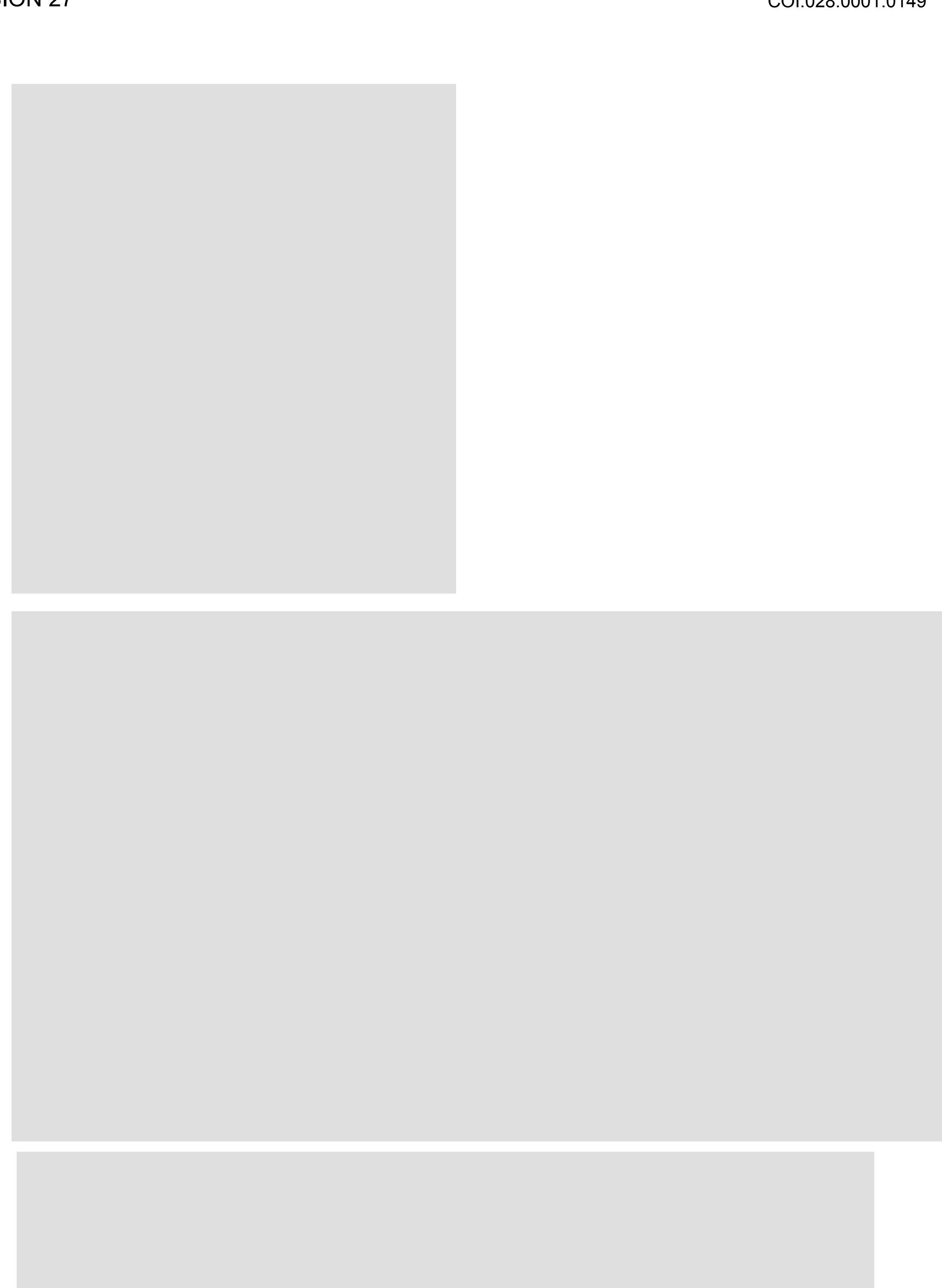
597 Exhibit 622, RCH clinical records [QHD.002.003.8999] at [.9150]-[.9180].

598 Exhibit 621, RCH clinical records, paras 8 and 9 [QHD.002.003.8621] at [.8764]-[.8832].

599 Exhibit 584, NGH clinical records [QHD.001.003.1440] at [.1686]-[.1772].

600 Exhibit 913, BAC clinical records [WMS.2002.0003.00105] at [.00138]-[.00144] and [WMS.2002.0003.00105] at [.00295]–[.00315].

601 Exhibit 913, BAC clinical records [WMS.2002.0003.00105] at [.00138]-[.00139].



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602 Exhibit 28, Statement of Anne Brennan, 23 October 2015 [DAB.001.0001.0001] at [0034].

603 Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 115 (e) [DAB.001.0001.0001] at [.0034]-[.0035].

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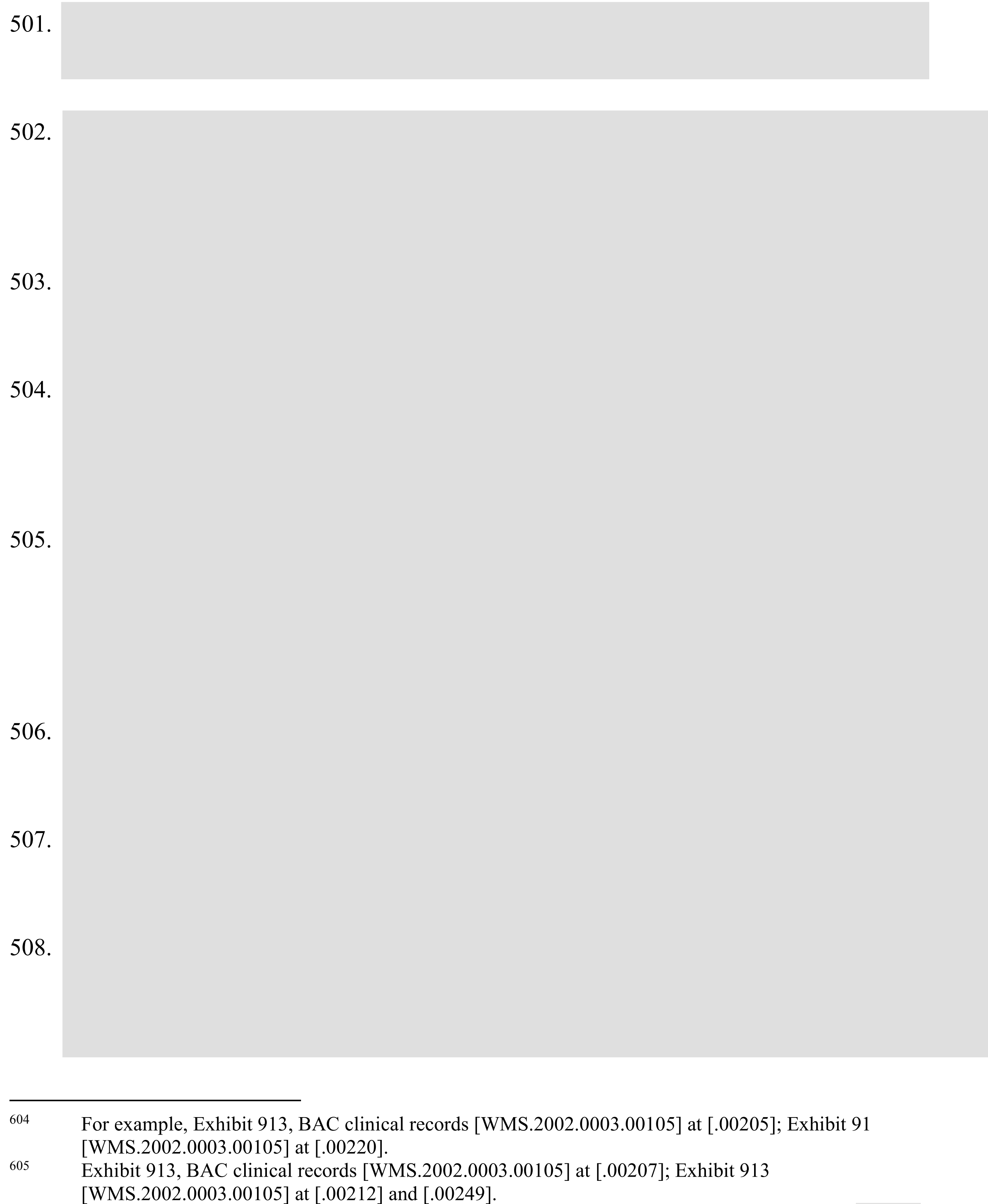

[604] For example, Exhibit 913, BAC clinical records [WMS.2002.0003.00105] at [.00205]; Exhibit 91 [WMS.2002.0003.00105] at [.00220].

[605] Exhibit 913, BAC clinical records [WMS.2002.0003.00105] at [.00207]; Exhibit 913 [WMS.2002.0003.00105] at [.00212] and [.00249].

[606] Exhibit 913, BAC clinical records [WMS.2002.0003.00105] at [.00254]-[.00258], [.00131] and Hospital clinical records.

[607] Exhibit 914, BAC clinical records [WMS.2002.0003.00369] at [.00425]. Also, an occasion Exhibit 911, BAC clinical records [WMS.2002.0002.03265] at [.03346]-[.03353].

[608] Exhibit 911, BAC clinical records [WMS.2002.0002.03265] at [03359]-[.03361].

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609 Exhibit 914, BAC clinical records [WMS.2002.0003.00369] at [.00416]-[.00417].

610 the report. Exhibit 914, BAC clinical records [WMS.2002.0003.00369] at [.00563].

611 Exhibit 914, BAC clinical records [WMS.2002.0003.00369] at [.00430]-[.00431].

612 Exhibit no. not yet allocated, BAC clinical records [WMS.2002.0003.00369] at [.00407].

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621 Exhibit 910, BAC clinical records [WMS.2002.0002.03036] at [.03038]-[.03042].

622 Exhibit 28, Statement Anne Brennan, 23 October 2015, para 115 (e) [DAB.001.0001.0001] at [0034]-[.0035].

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[623] Exhibit 910, BAC clinical records [WMS.2002.0002.03036] at [.03102].

[624] Exhibit 116, Statement of Ronald Simpson, 7 January 2016, paras 54(a)–(c), exhibit O and exhibit P [RSI.900.0001.0001] at [.0003].

[625] Transcript, Anne Brennan, 4 March 2016, p 20-65 lines 17–18.

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[626] Transcript, Ronald Simpson, 7 March 2016, p 21-100 lines 32–33 and Transcript, Anne Brennan, 4 March 2016, p 20-41 lines 9–23.

[627] Transcript, Anne Brennan, 4 March 2016, p 20-41 lines 41–5.

[628] Transcript, Anne Brennan, 4 March 2016, p 20-45 lines 1–2.

[629] Transcript, Anne Brennan, 4 March 2016, p 20-45 lines 4–23.

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[630] Transcript, Anne Brennan, 4 March 2016, p 20-75 lines 28-39.
[631] Transcript, Anne Brennan, 4 March 2016, p 20-75 lines 41–43.
[632] Transcript, Ronald Simpson, 7 March 2016, p 21-106 lines 11–34.
[633] Transcript, Anne Brennan, 4 March 2016, p 20-75 lines 35–42.
[634] Transcript, Anne Brennan, 4 March 2016, p 20-47 line 33 – p 20-48 line 7.

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635 Transcript, Ronald Simpson, 7 March 2016, p 21-102 lines 1–4.

636 Transcript, Ronald Simpson, 7 March 2016, p 21-102 lines 6–23.

637 Transcript, Anne Brennan, 4 March 2016, p 20-63 lines 5–10.

[638] Exhibit 28, Statement of Anne Brennan, 23 October 2015 [DAB.001.0001.0001].
[639] Exhibit 146, Statement of 7 January 2016 [WIT.900.016.0001] at [0005-0013].
[640] Exhibit 901, BAC clinical records Vol 1 of 4 [WMS.2002.0001.09383] at [09385].

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[641] Exhibit 28, Statement of Anne Brennan, 23 October 2015 [DAB.001.0001.0001] at [.0030].
[642] Exhibit 28, Statement of Anne Brennan, 23 October 2015 [DAB.001.0001.0001] at [.0030].

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643 Exhibit 28, Statement of Anne Brennan, 23 October 2015 [DAB.001.0001.0001] at [.0030]-[.0031].

644 Transcript, Trevor Sadler, 1 March 2016, p 17-40 lines 10–13.

645 Transcript 8 March 2016, p 22-35 lines 1–8.

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[646] Transcript, 8 March 2016, p 22-35 lines 41–47; Exhibit 146, 27 January 2016, para 89 [WIT.900.016.0001] at [.0021].

[647] Exhibit 359, Second supplementary statement of Anne Brennan, 22 February 2016 [DAB.005.0001.0001] at [.0024].

[648] Transcript, 8 March 2016, p22-36 lines 7–15; Exhibit 146, Statement of 27 January 2016 [WIT.900.016.0001] at [.0018].

[649] Transcript, 8 March 2016, p22-36 lines 17–18.

[650] Transcript, 8 March 2016, p22-36 lines 20–25; Exhibit 146, 27 January 2016 [WIT.900.016.0001] at [.0017].

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[694] Exhibit 92, Statement of Karen Northcote, 20 October 2015, paragraph 6(a) [MNH.005.003.0041].

[695] Exhibit 24, Statement of Emma Betson, 19 October 2015 [MNH.005.003.0001].

[696] Exhibit 477, Statement of 9 September 2014 [MNH.005.001.0018] at [.0023]-[.0024].

[697] Exhibit 22 , Statement of Emma Betson, 19 October 2015, paragraphs 9 and 10 [MNH.005.003.0001] at [.0002]; Exhibit 92, Statement of Karen Northcote, 20 October 2015, paragraph 6(a) [MNH.005.003.0041] at [.0042]-[.0043].

758 See Exhibit 117, Statement of Tania Skippen, 13 November 2015, Exhibit "R" [TSK.900.001.0001] at [.0671]-[.0675].

759 Exhibit 904, BAC clinical records Vol 9 of 9 [WMS.2002.0002.01066] at [.01221]-[.01222].

760 Exhibit 943, BAC clinical records Vol 1 of 9 [WMS.2002.0004.07026] at [.07032].

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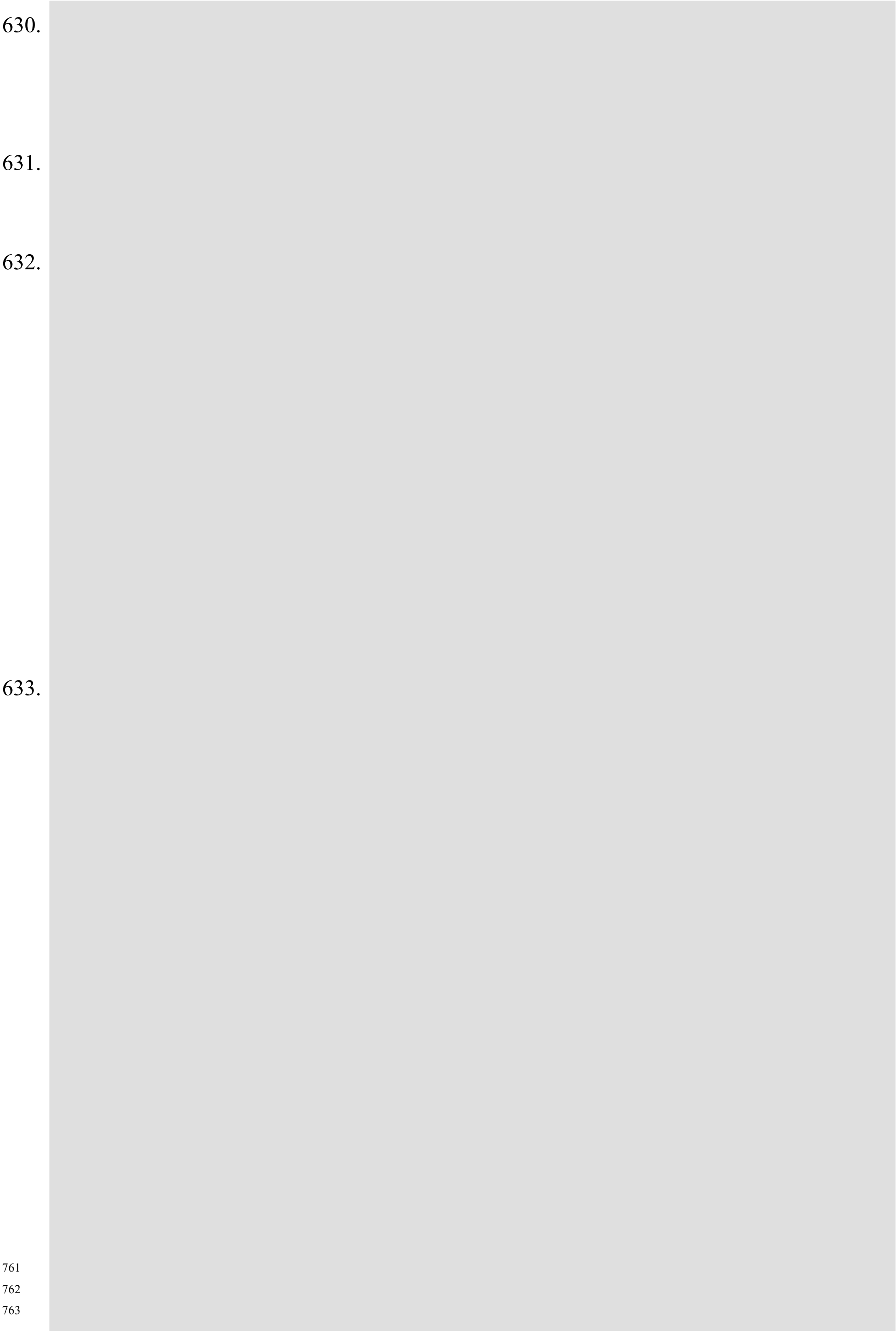

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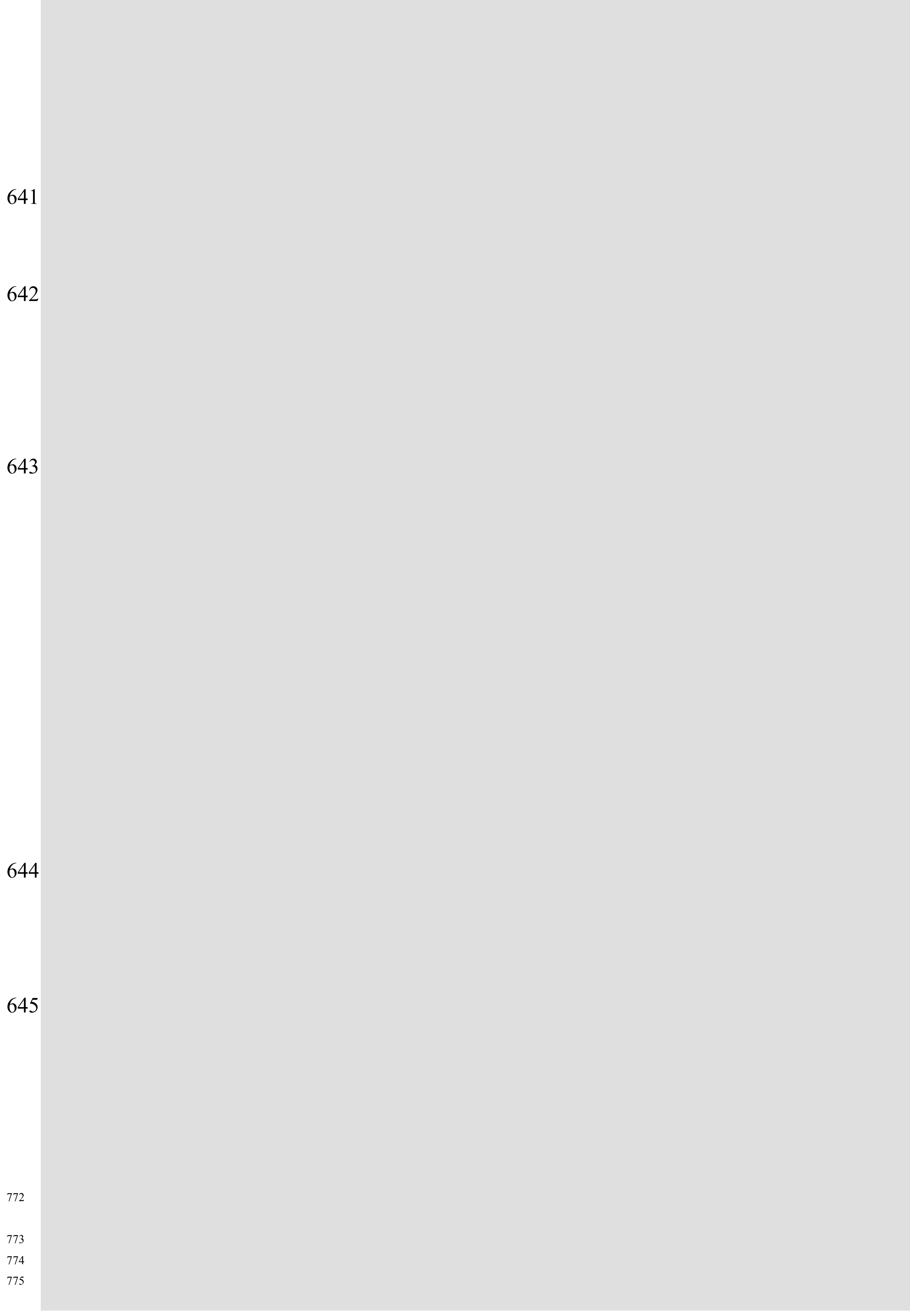

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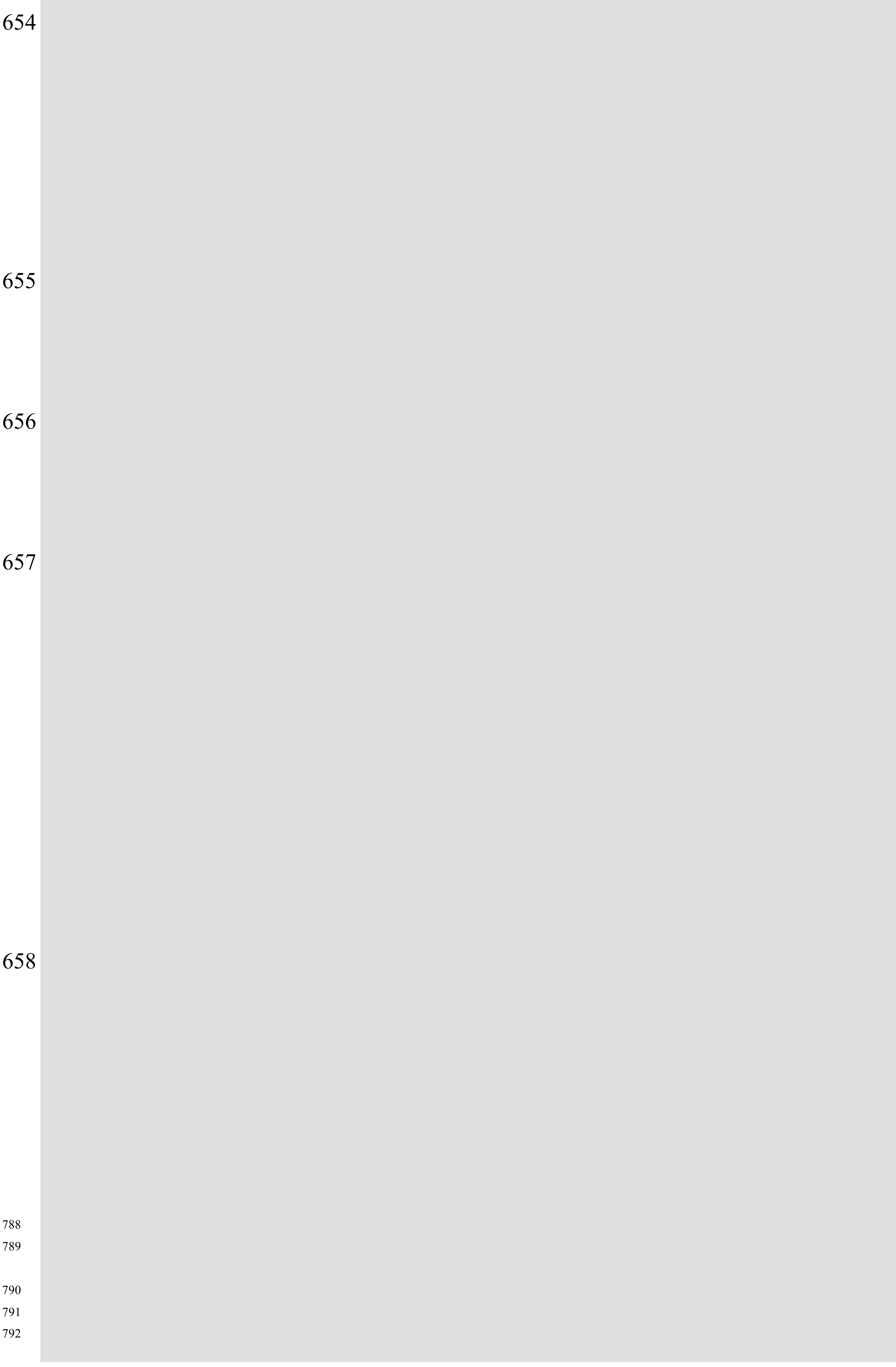

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806 Exhibit 28, Statement of Anne Brennan, 23 October 2015 [DAB.001.0001.0001] at [.0053].

807 Exhibit 28, Statement of Anne Brennan, 23 October 2015 [DAB.001.0001.0001] at [.0016]; Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016 [DAB.001.0003.0001] at [.0041].

PART J: SUPPORT TO THE FAMILIES OF TRANSITION CLIENTS [TOR 3(e) & (h)]

677. There is a dearth of evidence as to any formal process to provide care, support and services to families of transition clients. A Communication Plan and a Stakeholder Engagement Plan were developed by Rowdy PR in late 2012.[808] In these plans, Rowdy PR made recommendations in relation to the mode and frequency of communications with families of BAC patients.[809] However, the Commission has little evidence that, in practice, these plans were used to communicate with families.

678. In 2012, many families heard about Professor McDermott's unofficial announcement about the closure of the BAC through media reports.[810]

679. Following this, parents were involved in campaigning to keep the BAC open. Some families participated in the Save the Barrett online community and signed the e-petition to keep the BAC open.[811] Families also used the website as a source of information.[812] Families were in contact with the media, who reported on parents' concerns about the welfare of their children.[813] In September 2013, appeared in a radio interview expressing concerns about the treatment of following the closure of the BAC.[814]

680. A number of parents sent correspondence to the then Minister of Health and Premier expressing their support for the BAC. Parents received a standard letter in response which was drafted by Rowdy PR.[815] This letter assured families that no decision had been made about the BAC and that a decision would be made once the ECRG had finished its process

808 Exhibit 51, Statement of Naomi Elizabeth Ford, 1 December 2015, para 9 [RPR.900.001.0001] at [.0003].

809 Exhibit 51, Statement of Naomi Elizabeth Ford, 1 December 2015, para 10 [RPR.900.001.0001] at [.0003].

810 Exhibit 145, Statement of 10 February 2016, para 152 [FAM.900.013.0001] at [.0043].

811 Transcript, Lawrence Springborg, 26 February 2016, p 15-45 lines 10–11.

812 Exhibit 148, Statement of 15 December 2015, para 17 [FAM.900.002.0001] at [.0004].

813 Transcript, Lawrence Springborg, 26 February 2016, p 15-45 lines 15–19.

814 Exhibit 145, Statement of 10 February 2016, para 54 [FAM.900.013.0001] at [.0015].

815 Exhibit 51, Statement of Naomi Elizabeth Ford, 1 December 2015, para 15 [RPR.900.001.0001] at [.0004].

of reviewing models of care for adolescents requiring extended mental health treatment.[816]

681. Commencing on 30 November 2012, families received email updates on the BAC through a series of eleven fact sheets called "Fast Facts."[817] However, the emailing list did not include at least parent.[818] It seems the Fast Facts were useful in helping families understand the ECRG process,[819] however the Fast Facts "did not provide families with information about how the closure and transition of patients was going to work."[820]

682. In the Fast Facts dated 30 November 2012, families received assurance that they would receive updates on the progress of the BAC.[821]

683. The Commission has received evidence from parents of former BAC patients that, in the lead up to the closure announcement, there was a large amount of confusion and uncertainty surrounding the future of the BAC.[822] Families did not receive any Fast Facts between 21 May 2013 and 23 August 2013.[823] There was a lot of discussion at the BAC[824] and in the media about the BAC, which was distressing for families.[825]

684. There appears to have been several layers of communication with families regarding the closure of the BAC and the transition arrangements of patients.[826]

685. Families heard about the decision to close the BAC through a variety of ways. At the executive level, on the day of the Minister's announcement, Dr Sadler, Ms Kelly and Ms Dwyer attempted to telephone the parent/carer contact for each current BAC patient.[827]

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816 Exhibit 51, Statement of Naomi Elizabeth Ford, 1 December 2015 at Appendix L [RPR.900.001.0001] at [.00133].
817 Exhibit 51, Statement of Naomi Elizabeth Ford, 1 December 2015, para 9 [RPR.900.001.0001] at [.0003].
818 Transcript, 8 March 2016, p 22-16 line 42.
819 Transcript, 8 March 2016, p 22-17 lines 1–3.
820 Exhibit 148, Statement of 15 December 2015, para 19 [FAM.900.002.0001] at [.0004].
821 Exhibit 51, Statement of Naomi Elizabeth Ford, 1 December 2015 at Appendix 1 [RPR.900.001.0001] at [.00119].
822 Exhibit 146, Statement of 27 January 2016, para 59 [WIT.900.016.0001] at [.0014].
823 Transcript, 8 March 2016, p 22-15 line 42.
824 Exhibit 148, Statement of , 15 December 2015, para 19 [FAM.900.002.0001] at [.0004].
825 Exhibit 146, Statement of 27 January 2016, para 59 [WIT.900.016.0001] at [.0014].
826 Transcript, Carol Hughes, 3 March 2016, p 19-75 lines 10–11.
827 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, para 19.4 [WMS.9000.0006.00001] at [.00028].

However, many parents had already heard of the decision from their children during the day.[828] A follow up letter was sent by Ms Kelly,[829] however there is evidence that some families did not receive information from WMHHS until early November 2013.[830] This came to the attention of who informed Ms Kelly. In early November, Ms Kelly telephoned each parent/carer to confirm whether they had been receiving WMHHS's communications.

686. The method and frequency of contact with families during the transition period depended on the individual circumstances of the family and patient. It was the intention, with respect to transition, that each family be contacted[832] and be provided with assistance to participate in decision-making.[833] The transition checklist included "contact with families".[834] Case coordinators had responsibility for contacting families because of the relationships they had developed with the transition patients and their families.[835]

687. BAC social worker, Ms Hughes, was a member of the transition panels in order to ensure the inclusion and participation of families.[836] However, it appears that whilst she was certainly involved in contacting and providing support to families, she did not assume the role of ensuring that all families were involved and explained in oral evidence that she engaged with families on an "as needed" basis.[837] BAC occupational therapist, Ms Hayes', states in her supplementary statement, "responsibility for contacting families was a responsibility shared amongst clinical staff".[838]

688. Some parents took a proactive approach, such as who requested meetings with Dr Brennan and was in close contact with staff involved in transition.

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828 Exhibit 159, Witness Statement of 19 October 2015, para 13 [PAR.001.003.0001] at [.0002].

829 Exhibit 66, Statement of Sharon Kelly, 19 October 2015, para 19.5 and SK-25 [WMS.9000.0006.00001] at [.00029] and [.00940]

830 Exhibit 145, Statement of 10 February 2016, para 263 [FAM.900.013.0001] at [.0069].

831 Exhibit 66, Statement of Sharon Kelly, 19 October 2015, para 19.9 [WMS.9000.0006.00001] at [.00029]

832 Transcript, Carol Hughes, 3 March 2016, p 19-75 lines 9–10.

833 Transcript, Carol Hughes, 3 March 2016, p 19-77 lines 32–33.

834 Transcript, Carol Hughes, 3 March 2016, p 19-77 line 34.

835 Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 39 [DAB.001.0001.0001] at [0009].

836 Transcript, Carol Hughes, 3 March 2016, p 19-73 line 45 – 19-74 line 2.

837 Transcript, Carol Hughes, 3 March 2016, p 19-74 lines 33–35.

838 Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016, para 28.1 [WMS.9000.0029.00001] at [.00016].

689. The three statements of acknowledgment by Counsel for onfirm that they all had contact with Dr Brennan, their case coordinators and associate case co-ordinators, and other BAC staff regarding the transition arrangements for their children.[839]

690. An offer was made by Ms Kelly to families that they be contacted by telephone by the Consumer Advocate at The Park, Ms Nadia Beer. Families were required to respond to Ms Kelly with their contact details, which were provided to Ms Beer.[840] It appears that only parents took up this opportunity.[841] In her statement to the Commission, described this as a "gross invasion of privacy" and "intimidating" that parents were required to register their interest with the Executive Director of Mental Health Special Services of WMHHS.[842] had a brief conversation with Ms Beer, however in her statement to the Commission she says "it seemed that she was unable to assist us more than was already happening (i.e. receiving calls from the case workers). She definitely had no powers to change the prospect of the BAC closure or any further planning for alternate services."[843]

691. At weekly progress meetings, BAC staff discussed whether there was a need to include the family in the next meeting or discuss matters with the family.[844] Dr Brennan was in telephone contact with carers and facilitated family meetings with most families.[845] For some families, she was the main contact with respect to transition arrangements.[846] Ms Hughes gave evidence that during the family meetings she was sometimes required to provide counselling support to families.[847]

839 Exhibit 556, Acknowledgment of counsel of 11 March 2016; Exhibit 555, Acknowledgment of counsel of 11 March 2016; Exhibit 557, Acknowledgment of counsel of dated 11 March 2016.
840 Exhibit 145, Statement of 10 February 2016, para 205 [FAM.900.013.0001] at [.0057].
841 Exhibit 145, Statement of 10 February 2016, para 205 [FAM.900.013.0001] at [.0057]
842 Exhibit 145, Statement of 10 February 2016, para 205 [FAM.900.013.0001] at [.0057].
843 Exhibit 146, Statement of ary 2016, para 66 [WIT.900.016.0001] at [.0016].
844 Transcript, Carol Hughes, 3 March 2016, p 19-75 lines 14–.
845 Exhibit 28, Statement of Anne Brennan, 23 October 2013, paras 114 - 126 [DAB.001.0001.0001] [.0031].
846 Transcript, l, 8 March 2016, p 22-35 lines 46–47.
847 Transcript, Carol Hughes, 3 March 2016, p 19-74 lines 3–13.

692. It appears that families did not receive formal, written transition plans.[848] Some, if not all, families received a "Community Contacts" information sheet which provided families with contact details of alternative care arrangements. However, in tatement to the Commission, gave evidence that this information was of little assistance as one of the organisations listed in the document id not want to engage with that organisation.[849]

693. The Commission has received evidence from parents that they were concerned about the lack of information provided to them about their child's transition.[850] has given evidence that was not told that [51]

694. Similarly, gave evidence that following a meeting with Dr Brennan regarding from the BAC, was very concerned about

695. During the months following the closure announcement, parents and carers were concerned about the availability of replacement services for their children following the closure of the BAC.[853]

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848 Exhibit 150, Statement of ctober 2015, paragraph 34 [PAR.001.002.0001] at [.0005]; Exhibit 149, Stat 19 January 2016, paragraph 43 [WIT.900.010.0001] at [0009].

849 Exhibit 149, Statement of 19 January 2016, paragraph 49 [WIT.900.010.0001] at [.0010].

850 Exhibit 153, Statement of 21 October 2015, para 24 [PAR.001.001.0001] at [.0003]; Exhibit 150, Supplementary statement of 8 March 2016, para 29 [PAR.001.006.0001] at [.0004].

851 Exhibit 560, Supplementary statement o March 2016, para 29 [PAR.001.006.0001] at [.0004].

852 Exhibit 153, Statement of 21 October 2015, para 24 [PAR.001.001.0001] at [.0003].

853 Exhibit 145, Statement of 10 February 2016, para 171 [FAM.900.013.0001] at [.0047]. Exhibit 149, Statement 19 January 2016, para 52 [WIT.900.010.0001] at [0012].

696. A number of parents felt that the proposed transition arrangements were rushed,[854] inadequate and/or unrealistic.[855] Some families who lived in were concerned about the lack of services in their area.[856] They were concerned about their children being forced to be treated by adult services.[857] The BAC had been the last resort for many patients and families, and parents were anxious about the treatment of their children after the closure of the BAC gave evidence that the unavailability of a tier-3 model of care is what made the transition process difficult.[858] felt pressured to prematurely agree to an inadequate transition plan for [59] described the transition plan put forward for as "hollow", given that as refusing to engage with any other services.[860]

697. After some of the patients were transitioned from the BAC to their families, some families became concerned because they observed their children's condition deteriorate.[861]

698. Parents were given inconsistent and unrealistic messages with regards to the development of new services.[864] In early August 2013, parents were told that the BAC would continue to provide services until a new model became operational.[865] At least parents were assured that tier 3 options would be available when the BAC was closed.[866] However, by August/September 2013 it had become apparent, from the timeframe of events discussed

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[854] Exhibit 148, Statement of cember 2015, para 20 [FAM.900.002.0001] at [.0004]; Exhibit 149, Statement of uary 2016, para 48 [WIT.900.010.0001] at [.0010].

[855] Exhibit 146, Statement of January 2016, para 63 [WIT.900.016.0001] at [.0015]; Exhibit 159, Statement of 19 October 2015, para 21 [PAR.001.003.0001] at [.0004].

[856] Exhibit 146, Statement of 27 January 2016, paras 63 and 64 [WIT.900.016.0001] at [.0015].

[857] Exhibit 149, Statement of January 2016, para 52 [WIT.900.010.0001] at [.0011].

[858] Transcript, 8 March 2016, p 22-36 lines 35- 39.

[859] Exhibit 146, Statement of 27 January 2016, para 80 [WIT.900.016.0001] at [.0019].

[860] Exhibit 149, Statement of January 2016, paragraph 44 [WIT.900.010.0001] at [.0009].

[861] Transcript, 8 March 2016, p 22-20 lines 27–29.

[862] Exhibit 150, Statement o 21 October 2015, para 33 [PAR.001.002.0001 at .0005].

[863] Transcript, March 2016, p 22-41 lines 8–9.

[864] Exhibit 145, Statement of 0 February 2016, para 171 [FAM.900.013.0001] at [.0047].

[865] Transcript, 8 March 2016, p 22-26 lines 13–15.

[866] Transcript, 8 March 2016, p 22-35 line 5; Exhibit 145, Statement of 10 February 2016, para 171 [FAM.900.013.0001] at [.0047].

in the Fast Facts, that the transition of patients from the BAC and the development of new services were being treated differently.[867]

699. In statement to the Commission, describes feeling disappointed and worried after a meeting ad with Dr Brennan on 8 October 2013. tatement reads, "statements had previously been made about the government offering replacement services…however upon leaving this meeting I was left with the clear impressing that no new services were to be established."[868]

700. Parents were not consulted with respect to the development of new services until the lack of parent involvement was raised by [869] On 30 September 2013 parents were invited to make a submission to the SWAETRI Committee. It is vidence that this offer would not have been extended without the strong advocacy of parents.[870]

701. No doubt it will be contended that there was a parent/carer representative on both the ECRG and the SWAETRI Committee, however no contact was made by the parent/carer representative with other BAC parents.[871] equested to be in direct contact with the consumer and carer representative on the SWAETRI Committee, but this was refused due to confidentiality reasons.[872]

702. On 10 December 2013 a parent information session was held at The Park and parents were provided with information about the implementation of replacement services.[873] family members attended and amily member was an apology on the day.[874]

703. corresponded with a number of people within Queensland Health to express concerns as to the lack of replacement services for the BAC patients. Other parents were involved too. There is evidence that on at least occasions, parents/carers flew

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867 Transcript, 8 March 2016, p 22-26 lines 16–19.

868 Exhibit 146, , 27 January 2016, paras 71 and 72 [WIT.900.016.0001] at [.0017].

869 Transcript 8 March 2016, p 22-26 line 44 – 22-27 line 4.

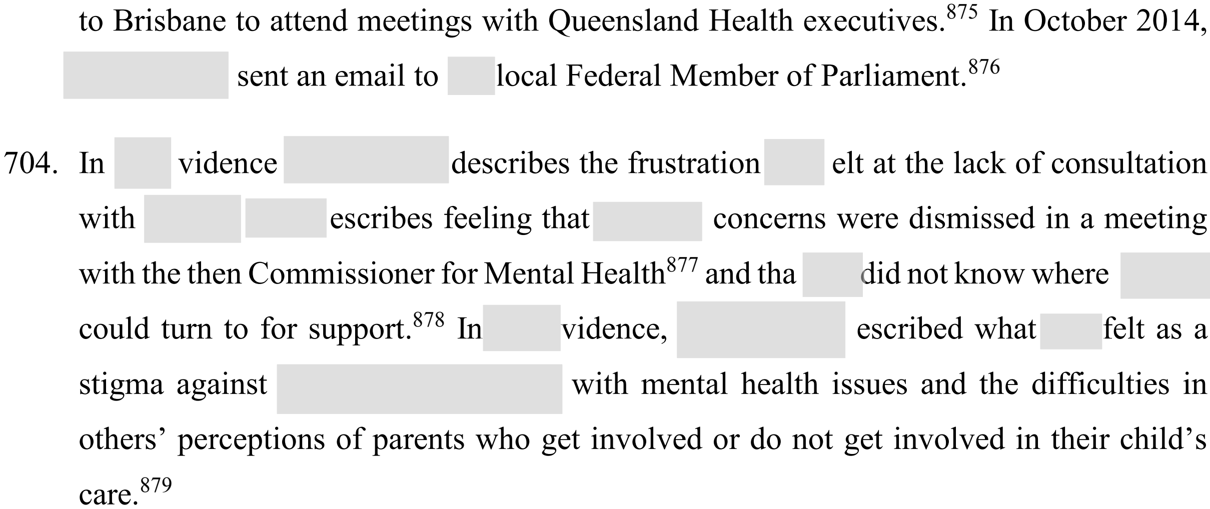
870 Exhibit 145, Statement of 10 February 2016, para 211 [FAM.900.013.0001] at [.0059].

871 Transcript, 8 March 2016, p 22-32 lines 30–45.

872 Exhibit 145, Statement of 10 February 2016, para 253 [FAM.900.013.0001] at [.0066].

873 Exhibit 127, Statement of Laura Tooley, 22 October 2015 at LT10 [WMS.9000.0002.00001] at [.00247].

874 Exhibit 127, Statement of Laura Tooley, 22 October 2015 at LT11 [WMS.9000.0002.00001] at [.00249].



to Brisbane to attend meetings with Queensland Health executives.[875] In October 2014, sent an email to local Federal Member of Parliament.[876]

704. In vidence describes the frustration elt at the lack of consultation with escribes feeling that concerns were dismissed in a meeting with the then Commissioner for Mental Health[877] and tha did not know where could turn to for support.[878] In vidence, escribed what felt as a stigma against with mental health issues and the difficulties in others' perceptions of parents who get involved or do not get involved in their child's care.[879]

Was there a process or plan for following up transition clients and their families after the closure? Who was responsible for any follow up?

705. Following the closure of the BAC, there was no process or plan for following up transition clients and their families. The Commission has received evidence that generally once a patient has been referred to another service, it is no longer the responsibility of referrer staff to follow up the patient. Despite this, Dr Brennan felt "a personal obligation to contact the receiving services" of many of the BAC patients.[880]

706. In the month following closure, Dr Brennan responded to calls from concerned families or care providers and made frequent telephone calls regarding the high risk patients who transitioned to other accommodation.[881] On two occasions, 29 January 2014 and 3 March 2014, she completed a review of all transition patients, an un-identified version of which she provided to the WMHHS Board.[882] This involved telephoning parents of patients who had been transitioned back to the family home.

Conclusions

875 Exhibit 145, Statement of 0 February 2016, paras 178, 232 and 262 [FAM.900.013.0001] at [.0049], [.0063] and [.0068].
876 Exhibit 146, Statement of uary 2016, para 78 [WIT.900.016.0001] at [.0018].
877 Exhibit 145, Statement of 10 February 2016, para 178 [FAM.900.013.0001] at [.0049].
878 Exhibit 145, Statement of 0 February 2016, para 178 [FAM.900.013.0001] at [.0049].
879 Transcript, 8 March 2016, p 22-29 lines 10–25.
880 Exhibit 28, Statement of Anne Brennan, 23 October 2013, para 161 [DAB.001.0001.0001] at [.0056].
881 Exhibit 28, Statement of Anne Brennan, 23 October 2013, para 158 [DAB.001.0001.0001] at [.0056].
882 Exhibit 28, Statement of Anne Brennan, 23 October 2013, para 159 and 160 [DAB.001.0001.0001] at [.0056].

707. The overwhelming evidence from families is that they were not adequately informed or consulted about the closure of the BAC, transition arrangements of their children and development of new services.

708. Families did not receive any Fast Facts from May 2013 to August 2013. Communication around the closure decision was poor, which created uncertainty and anxiety amongst families. Dr Brennan and BAC staff, particularly care coordinators, did their best to engage families in the transition arrangements. However, there was no strategy in place to ensure families were contacted or consulted. Families received mixed messages about the development of new services and which caused concern for the future of their children.

709. Families were not consulted about the closure of the BAC. Consultation about the development of new services only occurred after the insistence of parents themselves. To suggest that the parent/carer representatives, who had no contact with families, were representing the interests of the BAC parents on the ECRG and SWAETRI is disingenuous.

710. Given the ad-hoc approach to communication and consultation with families, Counsel Assisting submits that support provided to families was inadequate, particularly given the vulnerability of the BAC cohort.

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

What support was given to the BAC staff in relation to the closure and transitioning arrangements for transition clients?

General overview of the staffing structure of the BAC.

711. Upon its opening in 1986, the BAC employed 28 nursing staff, six allied health staff and three medical staff.[883]

712. In October 2012, these numbers had dropped to 20.9 nursing staff, five allied health staff and 1.8 medical staff.[884]

713. The allied health staff included one full time equivalent psychologist, one full time social worker, two full-time occupational therapist, a part-time speech and language pathologist, and a part-time specialist clinical supervisor.[885]

714. Dr Sadler said that from the time of the Redlands announcement in 2008, there was a reluctance to fill vacant BAC nursing positions with permanent staff.[886]

715. In 2012 the BAC school employed 5.3 full-time equivalent teacher roles, and this number stayed consistent over the following years.[887]

Communications with BAC staff (including education staff) during 2012 and 2013

716. Some staff became aware of the potential for closure after Professor McDermott's 'leak' in November 2012.[888]

717. On 9 November 2012, Ms Kelly and Ms Dwyer met with the BAC staff and school staff to correct what was described by Ms Kelly as "misreported information".[889]

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883 Exhibit 112, Affidavit of Trevor Sadler, 11 December 2015, paras 58-59 [DTZ.900.001.0001] at [.0013].
884 Exhibit 112, Affidavit of Trevor Sadler, 11 December 2015, para 60 [DTZ.900.001.0001] at [.0013].
885 Exhibit 112, Affidavit of Trevor Sadler, 11 December 2015, para 71 [DTZ.900.001.0001] at [.0015].
886 Exhibit 112, Affidavit of Trevor Sadler, 11 December 2015, para 65 [DTZ.900.001.0001] at [.0014].
887 Exhibit 106, Affidavit of Deborah Rankin, 11 October 2015, para 28 [DRA.900.001.0001] at [.0007].
888 Exhibit 137, Supplementary statement of Georgia Watkins-Allen, 30 January 2016, para 20 [GWA.001.002.0001] at [.0006]; Exhibit 36, Statement of Angela Clarke, 20 November 2015, paras 5.2 – 5.3 [WMS.9000.0014.00001] at [.00006]; Exhibit 109, Statement of Rosangela Richardson, 30 October 2015, para 13 [QNU.001.003.0001] at [.0008]; Exhibit 45, Statement of Susan Daniel, 29 October 2015, para 12(a) [QNU.001.004.0001] at [.0010].
889 Exhibit 45, Statement of Susan Daniel, 29 October 2015 at page 28 [QNU.001.004.0001] at [.0028].

718. At the meeting, staff were provided with reasons why the BAC may close. These were:

(a) that BAC model of service was outdated and/or it was more appropriate for adolescents to be treated closer to their homes and family;

(b) the building infrastructure was no longer fit for purpose;

(c) funding cuts; and

(d) that BAC patients were at a potential risk from adult patients at The Park.[890]

719. Staff were repeatedly told that no decision had been made about the BAC's future.[891]

720. Ms Kelly followed up the meeting with an email to all BAC staff. The email reassured staff that they (and unions) will be advised directly and in detail about whatever direction BAC services will take in the future. In particular, Ms Kelly wrote:

"Once any decision is made I am committed to consultation about the implementation of any organisational change, particularly in regard to minimising the impact of any change on staff."[892]

721. According to Ms Kelly, from this date until the BAC closed, she held "extensive meetings with staff around closure".[893]

722. When asked in cross-examination about meetings post November 2012, Ms Angela Clarke, speech pathologist, had the following response:

"I often walked away from those meetings having received information that was conflictual so, for example, in some meetings we were told there's no decision but within that same meeting we would often hear the opinion being given that, you

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[890] Exhibit 69, Statement of Mara Kochardy, 29 October 2015, para 14 [QNU.001.001.0001] at [.0010]; Exhibit 137, Supplementary statement of Georgia Watkins-Allen, 30 January 2016, para 22 [GWA.001.002.0001] at [.0006]; Exhibit 45, Statement of Susan Daniel, 30 October 2015, para 14 [QNU.001.004.0001] at [.0010]; Exhibit 109, Statement of Rosangela Richardson, 29 October 2015, para 14 [QNU.001.003.0001] at [.0009]; Exhibit 113, Statement of Stephen Sault, 15 December 2015, para 12 [QNU.001.008.0001] at [.0011].

[891] See Exhibit 66, Statement of Sharon Kelly, 16 October 2015, para 17.1 [WMS.9000.0006.00001] at [.00023]; Exhibit 177, Supplementary statement of Margaret Nightingale, 9 February 2016, para 36 [WIT.900.018.0001] at [.0008]; Exhibit 137, Supplementary statement of Georgia Watkins-Allen, 30 January 2016, para 20 [GWA.001.002.0001] at [.0006].

[892] Exhibit 45, Statement of Susan Daniel, 29 October 2015 at page 28 [QNU.001.004.0001] at [.0028].

[893] Exhibit 66, Statement of Sharon Kelly, 16 October 2015, para 17.2 [WMS.9000.0006.00001] at [.0024].

know, it couldn't stay open, it couldn't be rebuilt, we couldn't stay on the grounds of the forensic service [...]"[894]

723. Relevantly, prior to this in July 2012, Ms Kelly had directed staff not to make any recordings of formal or informal meetings with colleagues or management.[895]

724. At 3pm on 6 August 2013, prior to the Minister's announcement, Ms Kelly convened a meeting with the BAC staff. She advised staff that WMHHS had accepted all seven of the ECRG recommendations and that new, state-wide options for long-term adolescent mental health treatment would be explored. Staff were told these new options of care would be in place by early 2014.[896] Staff who were not present at the meeting received emails that night from Dr Geppert, attaching a copy of Ms Dwyer's media statement and the ECRG's recommendations.[897]

725. As for education staff, on 21 August 2013 Mr Blatch and Ms Dunker visited the BAC school to inform staff that the school would be relocating, given that Queensland Health, who owned the school buildings, would be shutting them down.[898] Subsequently, in a meeting on 6 November 2013, Mr Blatch informed education staff that a decision had been made to relocate the school to Yeronga for the 2014 school year.[899]

726. Communication from WMHHS management to staff about the actual date of closure was intermittent and vague. Multiple different dates were given to staff members, which caused confusion.

727. For example, Ms Sadler gave evidence that Ms Kelly told her in a meeting in 2012 that the BAC would close on 26 January 2013.[900] The first Staff Communique, dated 3

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894 Transcript, Angela Clarke, 29 February 2016, p 16-26, lines 24–28.

895 Exhibit 111, Statement of Kimberley Sadler, 14 December 2015, para 76 [WIT.900.012.0001] at [.0012] and Exhibit KS-11 at [.0058].

896 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, para 20.1 [WMS.9000.0006.00001] at [.00032] and Exhibit SK-30 [.01061].

897 Exhibit 129, Statement of Ashleigh Trinder, 30 October 2015 at Exhibit AT-4 [WMS.9000.0011.00001] at [.00049]; Exhibit 36, Statement of Angela Clarke, 20 November 2015 at Exhibit AC-11 [WMS.9000.0014.00001] at [.00075]; Exhibit 62, Statement of Megan Hayes, 20 November 2015 at Exhibit MH-03 [WMS.9000.0015.00001] at [.00038].

898 Exhibit 106, Statement of Deborah Rankin, 11 November 2015, para 62 [DRA.900.001.0001] at [.0016]; Exhibit 107, Supplementary statement of Deborah Rankin, 5 February 2016, para 20 [DRA.900.002.0001] at [.0008].

899 Exhibit 25, Statement of Peter Blatch, 22 October 2015, para 67 [DET.900.002.0001] at [.0022].

900 Exhibit 111, Statement of Kimberley Sadler, 14 December 2015 paragraph 74 [WIT.900.012.0001] at [.0012].

October 2013, listed January 2014 as the closure date.[901] Then, finally, a letter sent by Ms Kelly to all BAC staff on 16 December 2013 stated the services would cease as of 2 February 2014.[902]

728. Other staff members say they were never given a specific date for closure and had assumed this meant the BAC would remain open for as long as it took to find appropriate transition services for all patients.[903]

729. The bottom line is that the inconclusiveness of the closure date was frustrating for staff members and made it difficult to make decisions about their futures.[904]

730. Furthermore, even by January 2014, communication about the final closure date was not extended to some staff members. On 24 January 2014, Mr Sault was rostered for an afternoon shift. He was met at the BAC by Acting NUM Alex Bryce, who told him the BAC was now closed and requested his keys. Mr Sault noticed a locksmith changing the BAC locks.[905] Similarly, Ms Richardson returned to the BAC after a few days off at the end of January, to find the doors locked and that her keys no longer worked. She called the Acting NUM and was told the BAC was closed.[906]

731. The Department of Education (DETE) did not have any role or involvement in the decision to close the BAC. On 8 November 2012, Mr Blatch was advised informally by Dr Sadler that the BAC was likely to close, however no time frame was given.[907] This likelihood was confirmed by Ms Kelly in a telephone call a few days later. Mr Blatch noted that alternative arrangements regarding the school could not be made "until we knew what the transition or the new model of mental provision was going to be".[908]

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901 Exhibit 100, Supplementary statement of Kerrie Parkin, 19 January 2016, ex KP-2 [WMS.9000.0025.00001] at [.00012].

902 Exhibit 113, Statement of Stephen Sault, 15 December 2015 at page 40 [QNU.001.008.0001] at [.0040]

903 Exhibit 23, Statement of Matthew Beswick, 30 October 2015, para 25(a) [QNU.001.002.0001] at [.0014]; Exhibit 113, Statement of Stephen Sault, 15 December 2015, para 18 [QNU.001.008.0001] at [.0015]. See also Exhibit 87, Statement of Padraig McGrath, 16 November 2015, para 12.2 [WMS.9000.0012.00001] at [.00012].

904 Exhibit 99, Statement of Kerrie Parkin, 18 December 2015, para 5.6 [WMS.9000.0021.00001] at .00007].

905 Exhibit 113, Statement of Stephen Sault, 15 December 2015, para 16(d) [QNU.001.008.0001] at [.0015].

906 Exhibit 109, Statement of Rosangela Richardson, 30 October 2014, para 36 [QNU.001.003.0001] at [.0016].

907 Exhibit 25, Statement by Peter Blatch, 20 October 2015, para 32 [DET.900.002.0001] at [.0012].

908 Transcript, Peter Blatch, 25 February 2016, p 14-102 lines 18–19.

732. On 19 July 2013, Mr Blatch sent an email update to Ms Patrea Walton, Deputy Director General for State Schools, informing her that the decision to close would be announced by the Department of Health within the following two weeks. In that email he stated that "DETE had not been involved in any discussions and we were totally unaware prior to the [closure leak]".[909] Mr Blatch gave oral evidence that he would have hoped for earlier consultation regarding the closure decision, and that he was not sure if WMHHS had realised the BAC School was actually part of the Department of Education.[910]

733. Neither Mr Rodgers, the BAC School Principal, nor Ms Rankin, the Acting BAC School Principal, provided evidence of being consulted or involved in any way in relation to the decision to close.

How did the staff feel through the entire process?

734. It is apparent that, despite the closure announcement, BAC education staff were not concerned about their job security. Mr Rodgers gave evidence that Mr Blatch and Judith Dunker had "assured education staff that because of their expertise and the likelihood of there being a replacement for the [BAC], that every effort would be made to keep the education staff together".[911] In fact, Ms Rankin gave evidence that BAC school staff who were not permanent were offered permanency by the Department to Education, which she said "provided staff with a sense of security regarding their employment and allowed us to focus on the kids".[912]

735. As for nursing and allied health staff, the following description from the BAC's speech pathologist, Ms Clarke, of the period between November 2012 and January 2014 is apposite:

> *"During this 14 month period, I personally experienced distress and sleeplessness, hypervigilance regarding the short-term safety of patients, worry for the long-term welfare of patients and their families, anxiety at losing my job and guilt for being concerned for myself in the context of the distress of patients and their families."*[913]

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909 Exhibit 133, Statement of Patrea Walton, 21 October 2015 at Exhibit C [DET.900.001.0001] at [.0033].
910 Transcript, Peter Blatch, 25 February 2016, p 14-103 lines 44–47 and p 14-104 lines 1–10.
911 Exhibit 110, Statement of Kevin Rodgers, 10 December 2015, para 35 [WIT.900.014.0001] at [.0009].
912 Exhibit 106, Statement of Deborah Rankin, 11 November 2015, para 85 [DRA.900.001.0001] at [.0022].
913 Exhibit 36, Statement of Angela Clarke, 20 November 2015, para 18.1 [WMS.9000.0014.00001] at [.00038].

736. This is an insightful and reflective summary of how many of the BAC staff, mostly the permanent, long-term staff members, depicted the experience. Many health staff were torn between two immediate concerns: their future employment and the future of the patients.

737. From late 2012 the workplace was full of rumours about the BAC's future.[914] Staff became distressed and anxious and began to re-consider their employment at BAC.[915] According to Ms Trinder, it felt like the closure was "inevitable" and described it as feeling like a weight staff were carrying.[916] She said the uncertainty prevailed in day-to-day happenings at the BAC.[917]

738. During the period between November 2012 and the closure announcement, Mr McGrath said he was not informed of any specific staff concerns by the NUM but rather perceived the attitude to be that "'we've been through this before' and BAC had never been closed, so it would be the same this time."[918]

739. Mr Beswick said the closure decision "brought great uncertainty" and it "put a cloud over us."[919] Ms Kochardy recalled seeing staff "upset for the distress caused to the patients" and said "some staff members would cry to relieve their own distress".[920]

740. Ms Dowell reported the "highly emotive nature" of the Save the Barrett website and other petitions "caused further distress and anxiety for some staff for whom the decision to close BAC was already a highly emotional issue."[921]

741. Ms Dowell also said some staff felt the decision to close the BAC without a replacement facility reflected negative views that the "BAC and the model of care was not valued

914 Exhibit 47, Statement of Lorraine Dowell, 27 November 2015 paragraph 10.3(a) [WMS.9000.0016.00001] at [.00017]; Exhibit 77, Statement of Moira MacLeod, 5 November 2015, para 12(a) [QNU.001.007.0001 at .0008].

915 Exhibit 47, Statement of Lorraine Dowell, 27 November 2015, para 10.3(b) [WMS.9000.0016.00001] at [.00017]; Exhibit 137, Supplementary statement of Georgia Watkins-Allen, 30 January 2016, para 26 [GWA.001.002.0001] at [.0009]; Exhibit 45, Statement of Susan Daniel, 29 October 2015, para 16(c) [QNU.001.004.0001] at [.00013]; Exhibit 66, Statement of Sharon Kelly, 16 October 2015, para 16.1(c) [WMS.9000.0006.00001] at [.00023].

916 Transcript, Ashleigh Trinder, 2 March 2016, p 18-26 lines 39–43.

917 Transcript, Ashleigh Trinder, 2 March 2016, p 18-26 lines 39–43.

918 Exhibit 87, Statement of Padraig McGrath, 16 November 2015, para 6.11 [WMS.9000.0012.00001] at [.00006].

919 Exhibit 23, Statement of Matthew Beswick, 30 October 2015, para 30(k) [QNU.001.002.0001] at [.00016]

920 Exhibit 69, Statement of Mara Kochardy, 29 October 2015, para 30(f) [QNU.001.001.0001] at [.0016].

921 Exhibit 47, Statutory Declaration of Lorraine Dowell, 27 November 2015, para 10.3(b) [WMS.9000.0016.00001] at [.00017].

and/or adolescent complex care needs were not important to relevant decision makers or the clinical community."[922] She said staff felt there was a perception that the BAC was a "bad" model of care that needed to be removed from the service model, which in turn "led to staff feeling undervalued and defensive of the BAC model of care."[923]

742. With regard to evidence from the BAC school staff, Ms Oxenham felt that between the closure leak in November 2012 and closure announcement in August 2013, there was "a constant question of whether [the school] would continue to exist".[924] One BAC School teacher, Mr Bate, described the six months following the closure leak as "tumultuous, with the students and the wider school community trying to stop the closure of the Centre".[925]

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922 Exhibit 47, Statement of Lorraine Dowell, 27 November 2015, para 10.3(e) [WMS.9000.0016.00001] at [.00017].

923 Exhibit 47, Statement of Lorraine Dowell, 27 November 2015, para 10.3(f) [WMS.9000.0016.00001] at [.00017]

924 Exhibit 96, Statement of Justine Oxenham, 24 November 2015, para 10(a) [JOX.900.001.0001] at [.0005].

925 Exhibit 20, Statement of Darren Bate, 13 November 2015, para 21 [WIT.900.006.0001] at [.0007].

Impact on staff performance

743. There are mixed feelings about whether or not these emotions impacted on staff performance.

744. Ms Trinder said that, what she described as "confusion and chaos",[926] did impact her ability to provide individual therapy to patients. In particular, she said the uncertainty about her continued employment left her in an "ethical battle" as to whether she felt she could support and continue to support her current patients, when, for example, decisions had to be made about whether to pursue a course of treatment or not.[927]

745. Mr Beswick, on the other hand, was of the view that despite Dr Sadler's departure, the unit's imminent closure and loss of staff, the nursing staff continued to provide a high standard of care to their patients in the most difficult times.[928]

Was there confusion and anxiety amongst some of the BAC staff leading up to BAC closing is doors?

746. The evidence reveals varying levels of anxiety and confusion during the closure process. Most staff described at least some feeling of stress during this time. It was an inevitably uncomfortable time for staff members, some of whom had been at the BAC for many years.

747. The main causes of anxiety and confusion stemmed from the uncertainty of the closure date, as discussed previously; (touched on earlier in these submissions), and the changes of organisational structure. There was frustration at the lack of communication from management to staff about these issues.

748. Dr Pettet, who was the BAC Psychiatric Registrar from 5 August 2013 until November 2013, said many staff were confused as to why BAC was closing as there was, what he described as a "unanimous feeling that the facility was needed", especially considering its long waiting list.[929]

926 Exhibit 129, Statement of Ashleigh Trinder, 30 October 2015 at Exhibit AT-3 [WMS.9000.0011.00001] at [.00046].
927 Transcript, Ashleigh Trinder, 2 March 2016, p 18-26 lines 23–25.
928 Exhibit 178, Supplementary statement of Matthew Beswick, 12 February 2016, para 15(d) [QNU.001.002.0024] at [.0037].
929 Exhibit 103, Statement of Thomas Pettet, 4 December 2015, para 25(b) [DTP.900.001.0001] at [.0004].

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

749. Dr Sadler's has been described as an overwhelmingly negative experience for all involved.[930]

750. The day after Dr Sadler was Dr Pettet said staff members were called to a meeting room and advised that he had been He said they were not provided with reasons, but were instructed "not to discuss his dismissal with patients, patients' families, the media" or amongst themselves, or they would be subject to disciplinary action including the possibility of dismissal.[931]

751. Conversely, a number of staff including Ms Hayes,[932] Mr Huxter,[933] Ms Clayworth,[934] Ms Daniel[935] and Mr Page[936] were told that Dr Sadler was on leave or holidays, and were not aware that he had been ntil much later. Ms Clayworth also recalled being told at an executive meeting with either Ms Dwyer or Ms Kelly that "other staff members were not to communicate with Dr Sadler".[937] Importantly, Ms Clayworth remarked that had she been advised of the circumstances surrounding Dr Sadler's absence, she could have provided "more sensitive support" to staff.[938]

752. Mr Beswick felt as though most or all staff "held Dr Sadler in high regard" and that his departure "left a great hole in the unit".[939] In particular, he said:

> *"This profoundly affected me and I have no doubt that it affected other staff, patients and families alike. The unit lost its leader at a significant time as he left shortly after the closure announcement. It was like adding insult to injury."*[940]

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930 Transcript, Matthew Beswick, 29 February 2016, p 16-41 lines 25–32.
931 Exhibit 103, Statement of Thomas Pettet, 4 December 2015, para 29 [DTP.900.001.0001 at .0005].
932 Exhibit 62, Statement of Megan Hayes, 20 November 2015, para 3.1 [WMS.9000.0015.00001] at [.00002].
933 Exhibit 725, Statement of Liam Huxter unsigned version, para 19 [QNU.001.012.0001] at [.0009].
934 Transcript, Vanessa Clayworth, 8 March 2016, p 22-48 line 28.
935 Exhibit 45, Statement of Susan Daniel, 29 October 2015, para 17(b) [QNU.001.004.0001] at [.0013].
936 Exhibit 97, Statement of Brenton Page, 16 December 2015, paras 17 - 18 [WMS.9000.0020.00001] at [.00010].
937 Transcript, Vanessa Clayworth, 8 March 2016, p 22-49 lines 10–16.
938 Transcript, Vanessa Clayworth, 8 March 2016, p 22-48 lines 32–34.
939 Exhibit 178, Supplementary statement of Matthew Beswick, 12 February 2016, para 15(a) [QNU.001.002.0024] at [.0036].
940 Exhibit 178, Supplementary statement of Matthew Beswick, 12 February 2016, para 15(a) [QNU.001.002.0024] at [.0036].

753. Mr Beswick considered the decision to [redacted] Dr Sadler at such a crucial juncture an indication that the patients' best interests were not behind high level decisions.[941]

754. Ms Nightingale (BAC school teacher) described the removal of Dr Sadler as a key challenge in her role at the BAC school as "it was from that time that the multidisciplinary team seemed to fragment".[942] Rightly or wrongly she said there was "a general feeling that if they can remove Dr Sadler, what will they do with us?" and "a fear that Dr Sadler's removal was a tactic employed as part of the decision to close the BAC".[943]

755. Some staff were of the view that Dr Sadler's departure and Dr Brennan's commencement impacted on patient care and the facilitation of their transitions.

756. Mr Beswick pointed out that patients had to establish a rapport with a new consultant who did not know them and would be making major decisions about their future care.[944] He felt that despite Dr Brennan being a "competent, honest and hardworking clinician", Dr Sadler's "absence was disruptive in the extreme" to patients' care and therapy.[945]

757. Ms Hayes highlighted that Dr Sadler had a comprehensive knowledge of each adolescent's clinical presentation and had developed a therapeutic rapport which would have been invaluable to the transition process.[946] She added, however, that Dr Brennan "reduced the potential negative impact of his absence" through developing strong rapport with the adolescents and families and providing "strong clinical leadership and reassurances to staff".[947]

758. Professor McDermott said that at the time of Dr Brenan's appointment, he was alarmed that the staff were "chronically concerned about their jobs."[948]

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941 Exhibit 178, Supplementary statement of Matthew Beswick, 12 February 2016, para 15(c) [QNU.001.002.0024] at [.0038].
942 Exhibit 177, Supplementary statement of Margaret Nightingale, 25 January 2016, para 43 [WIT.900.018.0001] at [.0010].
943 Exhibit 177, Supplementary statement of Margaret Nightingale, 25 January 2016, para 46 [WIT.900.018.0001] at [.0010].
944 Exhibit 178, Supplementary statement of Matthew Beswick, 12 February 2016, para 15 [QNU.001.002.0024] at [.0037]
945 Exhibit 178, Supplementary statement of Matthew Beswick, 12 February 2016, para 15 [QNU.001.002.0024] at [.0037].
946 Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016, para 15.4 [WMS.9000.0029.00001] at [.00011].
947 Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016, para 15.5 [WMS.9000.0029.00001] at [.00011].
948 Transcript, Brett McDermott, 16 February 2016, p 7-33 line 5.

759. Dr Brennan said she was met with "an atmosphere of intense distress and uncertainty."[949] Staff were, as Dr Brennan stated, "very concerned about their own futures in terms of employment" and "there was constant discussion about date of closure as this was highly relevant to their seeking new employment or holding out for redundancies."[950]

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

760. Ms Lorraine Dowell was appointed by Ms Parkin in February 2013 to act as a liaison and support for allied health staff at BAC, and Mr Brennan was appointed to a similar role for nursing staff.[951]

761. Ms Dowell said she "provided individual support for staff regarding the organisational change process including providing advice on strategies to cope with the challenges and stressors associated with each stage of the change".[952]

762. After the closure announcement, Ms Dowell's role was to "support allied health staff through the organisational change process and to support positive engagement with the transition planning process to secure the best possible outcome for the patients."[953] Ms Dowell met weekly with allied health staff individually to "develop an appreciation of their circumstances and to identify the best way to support them as individuals."[954] In relation to patient transition, Ms Dowell supported staff by "guiding and directing the staff as to executing quality clinical handover."[955]

763. After Dr Sadler's Ms Dowell said she "spent time with allied health staff encouraging them to provide their complete support to Dr Brennan".[956]

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949 Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 129 [DAB.001.0001.0001] at [.0051].
950 Exhibit 28, Statement of Anne Brennan dated 23 October 2015, para 129 [DAB.001.0001.0001] at [.0051].
951 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, para 20.2 [WMS.9000.0006.00001] at [.00031]
952 Exhibit 47, Statement of Lorraine Dowell, 27 November 2015, para 10.1 [WMS.9000.0016.00001] at [.00016]
953 Exhibit 47, Statement of Lorraine Dowell, 27 November 2015, para 10.1 [WMS.9000.0016.00001] at [.00016]
954 Exhibit 47, Statement of Lorraine Dowell, 27 November 2015, para 10.2(c) [WMS.9000.0016.00001] at [.00016].
955 Exhibit 47, Statement of Lorraine Dowell, 27 November 2015, para 3.8 [WMS.9000.0016.00001] at [.00005].
956 Exhibit 47, Statement of Lorraine Dowell, 27 November 2015, para 9.5 [WMS.9000.0016.00001] at [.00015].

764. Mr Brennan gave oral evidence that he "visited the unit on a regular basis" and talked to nurses about specific requests they had leading up to the closure.[957]

765. In relation to education staff, Ms Rankin said that Mr Rodgers, Ms Wallace and herself supported education staff to the best of their abilities, by offering an open door policy and creating a collegial environment.[958] Self-care was spoken about and staff were encouraged to reflect on how they were responding to the constantly changing environment. Both Ms Rankin and Mr Rodgers encouraged Mr Blatch to visit the school regularly, and Mr Marriott also encouraged the Teachers Union to visit the school to support the staff.

766. Ms Lack, an Occupational Health and Safety Consultant, was also said to have assisted education staff in relation to self-care and coping skills.[959] She arranged a visit to the school by Mr Davidson, a Clinical Psychologist at Optum, who attended the school over a two day period to speak with staff.

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

767. A consistent thread in the BAC staff evidence is that, upon Professor McDermott's 'leak' in November 2012, permanent staff began to leave and were replaced by contract, agency and nursing pool staff.[960]

768. Ms Kelly acknowledged that this "inevitable departure" of staff would cause a loss of continuity of care and would impact upon patients' therapeutic recovery process.[961] Mr McGrath was also concerned about the loss of experienced staff after the closure announcement.[962]

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957 Transcript, William Brennan, 29 February 2016, p 16-55 lines 26–33.

958 Exhibit 107, Supplementary statement of Deborah Rankin, 5 February 2016, paras 32–36 [DRA.900.002.0001] at [.0010].

959 Exhibit 107, Supplementary statement of Deborah Rankin, 5 February 2016, paras 7–9 [DRA.900.002.0001] at [.0006].

960 Exhibit 23, Statement of Matthew Beswick, 30 October 2015, para 11(h) [QNU.001.002.0001] at [.0010]; Exhibit 66, Statement of Sharon Kelly, 16 October 2015, para 16.1(c) [WMS.9000.0006.00001] at [.00023]; Transcript, Matthew Beswick, 29 February 2016, p 16-42 lines 6–8; p 16-49 lines 44–47; Transcript, Moira Macleod, 7 March 2016, p 21-16 lines 21–25.

961 Exhibit 66, Statement of Sharon Kelly, 16 October 2015, para 16.1(c) [WMS.9000.0006.00001] at [.00023].

962 Exhibit 87, Statement of Padraig McGrath dated, 16 November 2015, para 20.2 [WMS.9000.0012.00001] at [.00023].

769. In July 2013, Dr Sadler noted a 25% reduction in the BAC nursing, allied health and medical staff since its opening in 1986. He became concerned that the loss of staffing numbers and experience was majorly impacting on the therapeutic efficiency at BAC.[963]

770. Indeed, staff members did notice a decline in the average skill level of the nursing staff, in that the new temporary staff members did not have the depth of experience as those who had left.[964] This caused challenges in the therapeutic recovery process due to patients not being familiar with the new or casual staff, who in turn did not have detailed knowledge of the patients.

771. Considering the complex nature of therapeutic relationships, some patients found it particularly hard to continue therapy progress with new staff members they did not know or trust.[965] Clinical Nurses attempted what was described as a "delicate balancing act" of allocating the most experienced staff with the most acute patients, whilst ensuring the staff do not become overwhelmed.[966] Mr Huxter observed "the adolescents felt there was little stability in their lives particularly with the staff leaving the BAC".[967] Ms Trinder said that as key staff left, themes of loss and abandonment emerged.[968] Ms Richardson said, after witnessing the loss of experienced staff, she made a conscious decision to stay to the end to provide some continuity of care to the patients.[969]

772. In addition to this, after the closure announcement and upon the commencement of transition processes, the workload for nurses and allied health intensified. Patients started acting out, and there was a noticeable surge in self harm and suicidal behaviour. It became apparent how vital it was for the experienced staff who remained to uphold the continuity of care. Staff members witnessed an increased responsibility placed on experienced nurses to make up for the lack of skill mix within the cohort.[970]

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963 Exhibit 112, Affidavit of Trevor Sadler, 11 December 2015 at Exhibit O [DTZ.900.001.0001] at [.0172].

964 Exhibit 69, Statement of Mara Kochardy, 29 October 2015, para 11(c) [QNU.001.001.0001] at [.0011]; Exhibit 23, Statement of Matthew Beswick, 30 October 2015, para 11(j) [QNU.001.002.0001] at [.0011]; Transcript, Matthew Beswick, 29 February 2016, p 16-42 lines 10–15.

965 Exhibit 178, Supplementary statement of Matthew Beswick, 12 February 2016, para 6(c) [QNU.001.002.0024] at [.0030].

966 Exhibit 45, Statement of Susan Daniel, 29 October 2015, para 5(b) [QNU.001.004.0001] at [.0004].

967 Exhibit 728, Statement of Liam Huxter unsigned version, para 17(e) [QNU.001.012.0001] at [.0009].

968 Transcript, Ashleigh Trinder, 2 March 2016, p 18-27 lines 10–15.

969 Exhibit 109, Statement of Rosangela Richardson, 30 October 2014, para 20 [QNU.001.003.0001] at [.0011].

970 Exhibit 109, Statement of Rosangela Richardson, 30 October 2014, para 34 [QNU.001.003.0001] at [.0015]; Exhibit 69, Statement of Mara Kochardy, 29 October 2015, para 11(c) [QNU.001.001.0001] at

773. The anxiety experienced by staff about their employment uncertainty was, it seems, transferred to the young people at the BAC. Dr Brennan said that it "seemed inappropriate for young people with their own significant anxieties" to have the level of "knowledge of staff's future employment prospects and the fact that they were exposed to the distress."[971] Further, she reported "concerns about keeping the remaining patients safe due to staffing levels and concerns about the impact of delays in funding arrangements to WMHHS."[972]

774. On the other hand, Ms Clayworth saw this change in nursing staff as an opportunity for other nursing staff to develop and progress in their careers, and become "true leaders".[973] As to nurses that left, she said it was timely for some of those nurses to leave to avoid becoming burnt out.[974] Ms Clayworth denied any depletion of experienced nurses at BAC from November 2012 onwards, believing instead that "the level of knowledge that was still there was a great level of knowledge".[975]

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

775. It is apparent from the evidence of staff members involved in the transitional arrangements that no timeframes were provided to staff to complete the transition of patients. They were also not consulted about what would be an appropriate timeframe.[976] Mr Beswick said he, therefore, assumed that the transition for each patient would take whatever time was needed to ensure the arrangement was appropriate.[977] He instead observed that timeframes seemed to be "accelerated compared with the timeframes taken prior to the closure announcement".[978] Mr Beswick, who was case coordinator for one transition patient, said some inpatients felt their transitional plans were inappropriate and

[.0011]; Exhibit no. not yet allocated, Statement of Liam Huxter unsigned version, para 17(d) [QNU.001.012.0001] at [.0009].

971 Exhibit 29, Supplementary statement of Anne Brennan, 27 January 2016, para 3 [DAB.001.0003.0001] at [.0002] and [.0003].

972 Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 152 [DAB.001.0001.0001] at [.0055].

973 Transcript, Vanessa Clayworth, 8 March 2016, p 22-56 lines 32–35.

974 Transcript, Vanessa Clayworth, 8 March 2016, p 22-56 lines 23–30.

975 Transcript, Vanessa Clayworth, 8 March 2016, p 22-56 lines 37–42.

976 Exhibit 45, Statement of Susan Daniel, 30 October 2015, para 21 [QNU.001.004.0001] at [.0014].

977 Exhibit 23, Statement of Matthew Beswick, 30 October 2015, para 25(a) [QNU.001.002.0001] at [.0014].

978 Exhibit 23, Statement of Matthew Beswick, 30 October 2015, para 25 [QNU.001.002.0001] at [.0014]

inadequate for them.[979] He subsequently delayed his holidays so he was available to look after the patients during their transition process.[980]

776. Community Liaison for the patient transitional planning group, Ms Daniel, similarly felt as though the transition arrangements were rushed. She described a "scurry to find places as quickly as possible for patients" as opposed to the usual gradual transition from institution to community.[981]

777. Dr Pettet said staff were very concerned about transitioning patients "who had clearly been benefiting from an inpatient facility", to other facilities that did not provide the staff profile or facilities to adequately contain or manage risk.[982] Dr Pettet's evidence was that he "lost six kilograms in weight" during his placement at the BAC due to stressors of the number of "acutely unwell" patients.[983]

778. Between September 2013 and January 2014, Ms Hayes noticed a general sense of urgency to transition the adolescents. She said this gained momentum after the closure decision was announced.[984]

779. Ms Hayes agreed that formal guidelines for transition would have assisted the process, and reduced the time transition staff spent on the task.[985] She said the transition process was frustrating and there was pressure to get the transition plans in place.[986]

780. Dr Brennan said that whilst many BAC staff had issues about the transition plans, others were supportive but felt they were unable to speak up due to "a perception that one did not care enough about the young people if one was prepared to progress these plans".[987]

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979 Exhibit 23, Statement of Matthew Beswick, 30 October 2015, para 30(d) [QNU.001.002.0001] at [.0016].

980 Exhibit 23, Statement of Matthew Beswick, 30 October 2015, para 30(n) [QNU.001.002.0001] at [.0017].

981 Exhibit 45, Statement of Susan Daniel, 29 October 2015, para 25 [QNU.001.004.0001] at [.0016].

982 Exhibit 103, Statement of Thomas Pettet, 4 December 2015, para 25 [DTP.900.001.0001] at [.0004].

983 Exhibit 103, Statement of Thomas Pettet, 4 December 2015, para 35 [DTP.900.001.0001] at [.0006].

984 Exhibit no. not yet allocated, Supplementary statement of Megan Hayes, 2 March 2016, para 5.7 [WMS.90000.0029.00001] at [.00005].

985 Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016, para 14 [WMS.9000.0029.00001] at [.00011].

986 Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016, para 14 [WMS.9000.0029.00001] at [.00011].

987 Exhibit 28, Statement of Anne Brennan, 23 October 2015, para 110 [DAB.001.0001.0100] at [.0127].

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

781. Generally the communiques did not confuse staff, but did not necessarily clarify anything either. The main issue was that staff were not given a specific closure date in these communiques.

782. Their stated purpose was to keep staff informed about what was happening and how it would impact them.[988]

783. This first communique contained information relating to staff transition processes, relevantly:

    (a) That Clinical Care Transition Panels had been planned for each individual young person at BAC;

    (b) That discussions had commenced regarding processes, options and issues for staff, and that Human Resources and senior clinical staff would soon contact staff individually to identify their individual employment options;

    (c) Staff were encouraged to access the Employee Assistance Program (EAP) at any time.[989]

784. Mr Sault said the closure date provided in this communique was stated to be "flexible" which he interpreted to mean the BAC may remain open past January 2014.[990]

785. On 4 November 2013, the second BAC staff communique from Ms Kelly was released. This second communique contained information relating to staff transition, relevantly, that the current workforce needs of the BAC staff will continue to be a high priority for WMHHS.[991]

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988 Exhibit 100, Supplementary statement of Kerrie Parkin, 19 January 2016 at Exhibit KP-2 [WMS.9000.0025.00001] at [.00012].

989 Exhibit 100, Supplementary statement of Kerrie Parkin, 19 January 2016, ex KP-2 [WMS.9000.0025.00001] at [.00012].

990 Exhibit 113, Statement of Stephen Sault, 15 December 2015, para 11(e) [QNU.001.008.0001] at [.0011].

991 Exhibit 100, Supplementary statement of Kerrie Parkin, 19 January 2016 at Exhibit KP-2 [WMS.9000.0025.00001] at [.00014].

786. This communique also confirmed that WMHHS Human Resources had “been on-site at BAC at various times across the last couple of weeks, to provide information and support to all interested staff about their future employment options”. It noted that discussions were ongoing with line managers regarding staffs’ particular preferences and any ongoing queries or feedback.

787. This communique encouraged staff to let their line managers know of additional methods of support or types of information they required.[992]

788. The third BAC staff communique from Ms Kelly was released on 6 December 2013.[993] This communique was much shorter than previous issues. It included an invitation to an information session on 10 December 2013 to BAC and West Moreton CYMHS staff by Dr Radovini (Child and Adolescent Psychiatrist, Director of Mindful, Centre for Training and Research in Developmental Health, the University of Melbourne, and Clinical Director of Headspace).[994] Dr Radovini’s session was described as an “opportunity for staff to hear about service delivery models from Victoria”.[995] Ms Hayes, Ms Hughes, Mr Beswick, Ms Kochardy and Dr Brennan all RSVP’d to this session.[996]

789. The fourth and final staff communique is dated 20 January 2014. In it, Ms Kelly confirmed that job matching had been completed for the majority of BAC permanent staff.[997] It then emphasised that staff who had not been job matched would have to choose between accepting a voluntary redundancy or pursuing transfer or redeployment.[998]

790. With regard to staff support, Ms Kelly wrote:

> *“I am very keen to ensure that all staff feel supported during the implementation of this change. It is important that you approach your supervisor or a more senior*

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992 Exhibit 100, Supplementary statement of Kerrie Parkin, 19 January 2016 at Exhibit KP-2 [WMS.9000.0025.00001] at [.00015].
993 Exhibit 100, Supplementary statement of Kerrie Parkin, 19 January 2016 at Exhibit KP-2 [WMS.9000.0025.00001] at [.00016].
994 Exhibit 100, Supplementary statement of Kerrie Parkin, 19 January 2016 at Exhibit KP-2 [WMS.9000.0025.00001] at [.00016].
995 Exhibit 127, Statement of Laura Tooley, 22 October 2015 at Exhibit LT-9 [WMS.9000.0002.00001 at .0214].
996 Exhibit 127, Statement of Laura Tooley, 22 October 2015 at Exhibit LT-11 [WMS.9000.0002.00001] at [.0250].
997 Exhibit 127, Statement of Laura Tooley, 22 October 2015 at Exhibit LT-07 [WMS.9000.0002.00001] at [.00176].
998 Exhibit 127, Statement of Laura Tooley, 22 October 2015 at Exhibit LT-07 [WMS.9000.0002.00001] at [.00176].

manager if you have any questions or concerns about the changes or how they may affect you. This is particularly important if you feel you need further detail about decisions taken or their impact. If your supervisor or manager does not know the answer to your question, they will escalate the issue and get back you as quickly as possible."[999]

791. The communique again encouraged staff to contact EAP for support including face-to-face and telephone counselling.

792. Mr Sault said the information provided in both the Fast Facts and the communiques meant he did not have concerns for the wellbeing of patients regarding the closure of BAC. He said he was satisfied from these newsletters that "an appropriate process was being undertaken by well qualified clinicians to ensure that the best possible model of care would be adopted to provide care for the patients" after closure.[1000]

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

793. Upon the closure announcement, permanent health staff members were told they had the option of either returning to their substantive position outside the BAC (if this was possible); redeployment elsewhere with WMMHS or another HHS; voluntary redundancy; or resignation to commence a role in private mental health services (if they are not eligible for voluntary redundancy).[1001] Temporary fixed term contracts were not renewed.[1002] The redeployment and redundancy processes of staff were conducted pursuant to three Directives.[1003] Redundancies were undertaken in accordance with the State-wide Voluntary Redundancy process.[1004]

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999 Exhibit 127, Statement of Laura Tooley, 22 October 2015 at Exhibit LT-07 [WMS.9000.0002.00001] at [.00176].

1000 Exhibit 113, Statement of Stephen Sault, 15 December 2015, para 14(a) [QNU.001.008.0001] at [.0013].

1001 Exhibit 99, Statement of Kerrie Parkin, 18 December 2015, para 5.8 [WMS.9000.0021.00001] at [.00008].

1002 Exhibit 99, Statement of Kerrie Parkin, 18 December 2015, para 4.11(a) [WMS.9000.0021.00001] at [.00005].

1003 Directive No 06/13: Commission Chief Executive Directive: Employees Requiring Placement; Directive 08/13: Minister Assisting the Premier Directive: Temporary Employment – End of Contract Payment; Directive No 11/12: Minister Assisting the Premier Directive: Early Retirement, Redundancy and Retrenchment. See Exhibit 99; Statement of Kerrie Parkin, 18 December 2015, para 5.3 [WMS.9000.0021.00001] at [.00006] and Ex KP-5 at [.00037].

1004 Exhibit 99; Statement of Kerrie Parkin, 18 December 2015, para 5.5 [WMS.9000.0021.00001] at [.00007].

794. Mr McGrath had oversight responsibility of BAC nursing staff and identifying roles within WMHHS to which BAC staff could transition. Both Mr McGrath and Ms Parkin said that WMHHS endeavoured to accommodate staff members' redeployment preferences, location preferences and eligibility for redundancy.[1005] Where a staff member was matched to a position, Mr McGrath would facilitate the transition in terms of "timing, orientation to the new unit, the provision of training to successfully transition to the new role and support to ensure success of the transition".

795. On 16 January 2014, WMHHS conducted interviews with all permanent nursing and allied health staff to determine suitability for alternative substantive positions.[1006] Both Mr Beswick and Mr Sault gave evidence that this interview felt like a "job interview".[1007]

796. In January 2014, ten staff members were successfully job-matched to direct-transfer jobs.[1008] They were sent letters from Ms Kelly advising them of this job match in late January 2014.[1009]

797. Education staff, as noted previously, were advised by the DETE that their employment would be secure. They were told that they were regarded as "an expert team that would be kept together while a future model of education for adolescents with mental health issues was developed".[1010]

How were BAC staff assisted to deal with the stress?

[1005] Exhibit 99; Statement of Kerrie Parkin, 18 December 2015, para 5.11 [WMS.9000.0021.00001] at [.0008].

[1006] Exhibit 99; Statement of Kerrie Parkin, 18 December 2015, para 5.13(c) [WMS.9000.0021.00001] at [.0009].

[1007] Exhibit 727, Supplementary statement of Stephen Sault, 25 February 2016, para 25 [QNU.001.008.0046] at [.0067]; Exhibit 23, Statement of Matthew Beswick, 30 October 2015, para 32(a) [QNU.001.002.0001] at [.0018].

[1008] Exhibit 99, Statement of Kerrie Parkin, 18 December 2015 at Exhibit KP-04 [WMS.9000.0021.00001] at [.00036]. Note: the calculation of 10 staff members includes Lorraine Dowell who is not included on this table.

[1009] See Exhibit 113, Statement of Stephen Sault, 15 December 2015, para 14 [QNU.001.008.0001] at [.0013]; Exhibit 47, Statement of Lorraine Dowell, 27 November 2015 at Exhibit LMD-3 [WMS.9000.0016.00001] at [.00035].

[1010] Exhibit 106, Statement of Deborah Rankin, 11 November 2015, para 88 [DRA.900.001.0001] at [.0023]; Exhibit 107, Supplementary statement of Deborah Rankin, 5 February 2016, para 40 [DET.900.002.0001] at [.0011].

800. It is apparent that Ms Dowell was a valuable addition to allied health staff support. Ms Parkin gave evidence that she "observed Ms Dowell provided very substantial emotional support to BAC staff" in response to their concerns.[1011]

801. Further, Ms Clayworth gave evidence that, upon the closure announcement, she ensured she was available to provide debriefing with nursing staff on shift. She said she stayed until 9:30pm at night to support the staff. Ms Clayworth said she also provided individual counselling for some staff.[1012]

802. As noted above, staff were also regularly encouraged to contact EAP for support during the closure process. Ms Parkin described this as "a primary mechanism through which Human Resources Services provides for the emotional and psychological support to staff". This was relied upon quite heavily by WMHHS Human Resources as a support to staff. Ms Clayworth also gave evidence that she "made it well known to staff that [EAP] would come onsite should they want that in a group setting as well".[1013]

803. EAP is a well-known government counselling and support resource and it is understandable, the Commission submits, that Human Resources would rely upon this tool for its staff. Its use is confidential and therefore it is not known how many, if any, BAC staff members utilised this service. A conclusion may be drawn, however, that encouraging its use was not entirely effective by itself, when one considers the evidence of some BAC staff about receiving support.

804. Whilst some staff members do recall being directed to access EAP support if they desired,[1014] Ms Richardson,[1015] Ms Kochardy,[1016] Mr Huxter,[1017] Mr Beswick,[1018] Ms

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1011 Exhibit 100, Supplementary statement of Kerrie Parkin dated 19 January 2016, para 4.2(b)(i) [WMS.9000.0025.00001] at [.00003].
1012 Transcript, Vanessa Clayworth, 8 March 2016, p 22-47 line 44; p 22-48 line 3.
1013 Transcript, Vanessa Clayworth, 8 March 2016, p 22-48 lines 21–23.
1014 Exhibit 111, Statement of Kimberley Sadler, 14 December 2015, para 69 [WIT.900.012.0001] at [.0011]; Exhibit 46, Supplementary statement of Susan Daniel, 10 February 2016, para 16 [QNU.001.004.0038] at [.0056]; Exhibit 113, Statement of Stephen Sault, 15 December 2015, para 25 [QNU.001.008.0001] at [.0023].
1015 Exhibit 109, Statement of Rosangela Richardson, 30 October 2015, para 33 [QNU.001.003.0001] at [.0016].
1016 Exhibit 69, Statement of Mara Kochardy, 29 October 2015, para 33 [QNU.001.001.0001] at [.0017]; Exhibit 70, Supplementary statement of Mara Kochardy, 8 February 2015, para 5(b) [QNU.001.001.0023] at [.0030].
1017 Exhibit 728, Statement of Liam Huxter unsigned version, para 46 [QNU.001.012.0001] at [.0024].
1018 Exhibit 23, Statement of Matthew Beswick, 30 October 2015, para 33 [QNU.001.002.0001] at [.0019].

MacLeod,[1019] Ms Yorke[1020] and Ms Young[1021] all said they were not offered or do not recall being offered any support between August 2013 and their last day at the BAC.

805. Other staff members said that they did not know what support was offered because they did not seek it out.[1022]

806. It is apparent that the most effective support mechanism utilised by staff was simply a "coming together" of BAC colleagues to support each other.[1023] Mr Beswick's evidence was that "the effect on staff was significant" but that the staff were very professional and supported each other as best they could in the circumstances.[1024] Ms Hayes said colleagues provided "peer support and a collaborative working environment during a difficult time".[1025]

807. Some staff were of the view that better support could have been provided through offering debriefing processes, where staff could reflect and let go of a significant part of their professional lives.[1026]

808. Mr Sault felt that "once the BAC closed, there was no acknowledgement given to the staff of the BAC of the efforts they made to care for the patients of the BAC. There was no debrief. The doors closed and that was the end of the BAC".

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

1019 Exhibit 77, Statement of Moira MacLeod, 5 November 2015, para 33 [QNU.001.007.0001] at [.0015].

1020 Exhibit 142, Statement of Peta-Louise Yorke, 2 November 2015, para 33 [QNU.001.006.0001] at [.0016].

1021 Exhibit 143, Statement of Victoria Young dated 30 October 2015, para 33 [QNU.001.005.0001] at [.0013].

1022 Exhibit 97, Statement of Brenton Page, 16 December 2015, para 30 [WMS.9000.0020.00001] at [.00024]; Exhibit 141, Supplementary statement of Lourdes Wong, 9 February 2016, para 8 [QNU.001.009.0016].

1023 Exhibit 109, Statement of Rosangela Richardson, 30 October 2015, para 33 [QNU.001.003.0001] at [.0016]; Exhibit 70, Supplementary statement of Mara Kochardy, 8 February 2015, para 5(a) [QNU.001.001.0001] at [.0030]; Exhibit 23, Statement of Matthew Beswick, 30 October 2015, para 33 [QNU.001.002.0001] at [.0019]; Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016, para 28.8 [WMS.9000.0029.00001] at [.00017]; Exhibit 77, Statement of Moira MacLeod, 5 November 2015, para 33 [QNU.001.007.0001] at [.0015].

1024 Transcript, Matthew Beswick, 29 February 2016, p 16-39 lines 27–36.

1025 Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016, para 28.8 [WMS.9000.0029.0001] at [.00017].

1026 Exhibit 971, Supplementary statement of Megan Hayes, 2 March 2016, para 28.9 [WMS.9000.0029.00001] at [.00017]; Exhibit 70, Supplementary statement of Mara Kochardy, 8 February 2015, para 5(b) [QNU.001.001.0023].

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[1027] Exhibit 20, Statement of Darren Bate, 13 November 2015, para 44 [WIT.900.006.0001] at [0011]; see also at [.0031].
[1028] Exhibit 20, Statement of Darren Bate, 13 November 2015, para 44 [WIT.900.006.0001] at [0011]; see also at [.0031].
[1029] Exhibit 20, Statement of Darren Bate, 13 November 2015 at page 51 [WIT.900.006.0001] at [.0051].
[1030] Exhibit 45, Statement of Susan Daniel, 29 October 2015, para 19(f) [QNU.001.004.0001] at [.0014].
[1031] Exhibit 53, Statement of Kristi Geddes, 22 October 2015 at Appendix KP-59 [KGE.001.001.001] at [.059].
[1032] Exhibit 45, Statement of Susan Daniel, 29 October 2015, para 19(f) [QNU.001.004.0001] at [.0014].
[1033] Exhibit 46, Supplementary statement of Susan Daniel, 10 February 2016, para 17(b) [QNU.001.004.0038] at [.0057].
[1034] Exhibit 53, Statement of Kristi Geddes, 22 October 2015 at Appendix KP-59 [KGE.001.001.001] at [.059].
[1035] Exhibit 46, Supplementary statement of Susan Daniel, 10 February 2016, para 18(a) [QNU.001.004.0038] at [.0057].
[1036] Exhibit 137, Supplementary statement of Georgia Watkins-Allen, 30 January 2016, para 63 [GWA.001.002.0001] at [.0019].

813.

Conclusion

814. It is inevitable that the loss of employment is an emotional and unpleasant experience. Indeed, it is perhaps amplified in the context of long-term staff caring for a highly vulnerable group of young people. It is accepted that no level of support could have completely alleviated this discomfort for staff.

815. There are certainly some validly held staff criticisms of WMHHS executives' handling of job uncertainty, general communication to staff, and the lack of leadership leading up to the closure. The overriding theme of BAC staffs' evidence is, however, that line managers and clinicians 'on the ground' did the best they could to support staff in very challenging circumstances.

[1037] Exhibit 137, Supplementary statement of Georgia Watkins-Allen, 30 January 2016, para 63 [GWA.001.002.0001] at [.0019].

[1038] Exhibit 142, Statement of Peta-Louise Yorke, 2 November 2015, para 36 [QNU.001.006.0001] at [.00017].

[1039] Exhibit 142, Statement of Peta-Louise Yorke, 2 November 2015, para 36 [QNU.001.006.0001] at [.00017].