Discussion Paper No. 3: Directions Hearing on 28 January 2016

Introduction

1. A number of issues are to be considered at the directions hearing on 28 January 2016. Those issues are the subject of helpful submissions from the parties.

2. The purpose of this discussion paper, written by counsel assisting, is to distil each of the issues and to present some preliminary views and in some cases some suggested solutions which might be put to the Commissioner as agreed positions. The legal representatives for the parties are invited to express their views.

Closed Hearings

3. The joint submissions at paragraphs 4-19 carefully explain the issues, and the risks, and the appropriateness of closed hearings. Similar submissions are made by Avant on behalf of Dr Brennan.[1]

4. It is appropriate that there be closed hearings. Essentially, closed hearings are appropriate in two types of situations:

   (a) Full Closed Hearings – Where former patients, or their families, give evidence it is proposed that the evidence of those persons be held in a closed hearing.

   (b) Partial Closed Hearings – For other witnesses, some of their evidence will be able to be held in open hearings but when the witness' evidence covers individual patients, or specific events involving patients, that part of the witness' evidence will need to be closed.

5. Counsel assisting proposes to discuss with the legal representatives for the parties:

   (a) a method of carefully and simply communicating to counsel, solicitors and the witnesses the types of evidence that will need to held in closed session (a short note or guide may assist witnesses in particular);

[1] Submissions of Avant dated 21 January 2016 at paras 1 and 2.

(b) endeavouring to identify in advance, those areas of a witness' evidence that will need to be held in a closed hearing and, if possible, sequencing that evidence at the end of the witness' testimony (we accept that, in some cases, this may be difficult);

(c) the procedures for closed hearings (i.e. who ought to be permitted in the closed session; how it should be organised; confidentiality undertakings for those permitted with closed sessions).

Inappropriate Models - Avant Submission No. 3

6. Paragraph 3 of Avant's submissions on behalf of Dr Brennan is in these terms:

> *In our submission the Commission should insist that media reporting does not identify a particular model of treatment or a place or location of treatment as good or bad. While there will rightly be a focus on what is the appropriate model of care for different patients or cohorts of patients, to suggest in reporting before findings are made that there is evidence that one model or place of treatment was inappropriate for a particular patient or cohort of patients may well cause harm to persons who were or currently are patients within that model of care or place of care. Conversely suggesting that a model is the best model for a patient or cohort of patients may undermine the therapeutic relationship and engagement for persons who are or were in different models of care or places of care.*

7. Whilst one can have sympathy for that view, there are problems:

(a) the expert evidence tendered so far does not suggest that discussion of models of care is likely to lead to any harm;

(b) it would be difficult for the Commission to '*insist*' that reporting not include discussions of models of care – an issue central to the Commission's terms of reference – and if the Commission did make such an order it would leave very little to be reported;

(c) there may be a legitimate public interest in properly understanding the competing arguments about different models of care – the models of care involve the use of public money and matters of legitimate public interest.

8. Some evidence and further submission would be required to justify an order under s 16 of the *Commissions of Inquiry Act 1950* prohibiting publication of that type of material.

Advice of Psychiatrist - Avant Submission No. 4

9. Avant also suggest that the media be encouraged to provide draft articles to a psychiatrist nominated by the Commission or RANZCP so that advice can be given as to whether the proposed article may cause harm, and whether alterations to the proposed article might avoid harm.

10. The Commission has already arranged a meeting of the parties and media representatives with a view to reinforcing the need for restraint and alerting the parties and the media to the *Mindframe* and similar guidelines. That meeting occurred on 22 January 2016.

11. One problem with this proposal is that the Commission has no power to direct media to take such a step prior to publication. And so, such a scheme relies on the media being '*encouraged*' to adopt such a step. It is to be doubted that media organisations will agree to such a step.

12. And, if a media representative wished to do so, it is likely that they could easily access appropriate psychiatric advice.

Professor Crompton – Metro South

13. Metro South submits that the parts of Professor Crompton's evidence that relate to three patients transitioned to Metro South ought to be heard in closed hearings.

14. That is consistent with the views of counsel assisting. Professor Crompton's evidence ought to be partially heard in a closed hearing. The closed hearing aspect is likely to involve any evidence concerning paragraphs 83 – 90 inclusive of Professor Crompton's witness statement.

15. The issue of what evidence of Professor Crompton should be the subject of closed hearings can be the subject of discussion between counsel assisting and counsel for Metro South. Similarly for other witnesses and parties.

Cross-Examination

16. Counsel assisting are grateful to those parties who expressed a view on the witnesses they may wish to cross-examine, and the likely time estimates. Those (non-binding) estimates will assist the Commission staff with on-going timetabling.

17. Suffice it to say that no estimate appears unreasonable at this stage. Of course, cross-examination will be subject to the directions of the Commissioner.

State Submissions – Consent

18. There is force in the State's submissions[2] that the provision of consent by family members does not necessarily avoid the risk of harm. In general, it is agreed that the evidence of patients and family should be conducted entirely in closed hearings.

19. Partial closed hearings for some witnesses is also proposed.

20. Similarly, there is force in the State's submissions that, even where there have been previous press reports, patient information ought to be kept confidential during Commission hearings.

21. As it happens, the legal representatives for the families of the deceased young people wish to maintain confidentiality.[3]

22. One aspect that the parties need to consider is whether names and dates of the 3 suicides, are matters that ought to be the subject of closed hearings. Our present thinking is that those facts, without the detail, are validly part of the open hearings. However, we seek the views of the parties via their legal representatives.

Evidence Regarding Standing Down of Dr Sadler

23. Both the State and Roberts & Kane (for a number of nurses) submit that the evidence about Dr Sadler's suspension should be conducted in closed hearings.

24. Counsel assisting ask for the parties input on a proposal that attempts to draw a line between 2 types of evidence, namely:

    (a) provided the details or reasons for Dr Sadler's suspension or the facts behind the suspension are not dealt with, there can be '*open*' evidence of the events in general

2 State's submissions on Cross-Examination/Closed Hearings at paras 18 – 22.
3 Submissions of Mr Mullins, Mr Harper and Mr Wessling-Smith dated 21 January 2016 at para 8.

covering the fact of the suspension and any clinical governance issues that are said to arise;

(b) however, any discussion of the details or reasons for the suspension, or the facts behind or leading to the suspension, ought to be conducted in closed hearings.

25. A meeting or teleconference can be held with the relevant legal representatives and counsel assisting to endeavour to agree on the extent to which the evidence relating to the Sadler suspension can be held in open hearing.

Distribution of Mindframe Guidelines

26. Counsel assisting agree with the State's submission that the Commission staff should make copies of the *Mindframe Guidelines* available on 28 January 2016 and otherwise during the hearings.

Access to Documents/Procedural Fairness

27. The legal representatives of Mr Springborg have raised previously issues related to access to documents and procedural fairness. Those issues have been addressed in correspondence. Counsel assisting request that any issues that Mr Springborg wishes to raise at the directions hearing, or any orders or directions that are sought, be properly explained so that the issues can be considered by the Commission and the parties.

28. If any party considers that they are being prejudiced by a lack of access to documents, they are invited to raise it with counsel assisting or to write to the Commission's Executive Director, Mr Ashley Hill.

Parliamentary Privilege

29. Some documents produced to the Commission are subject to parliamentary privilege. The Commission is conscious of the requirement of s 8(1) of the *Parliament of Queensland Act* 2001 which provides that:

> *The freedom of speech and debates or proceedings in the Assembly cannot be impeached or questioned in any court or place out of the Assembly.*

30. The legal representatives of the parties should be aware of this privilege when cross-examining witnesses.

Variations to Orders – Further Legislative References

31. A copy of the order made on 15 October 2015 is Attachment 1. The joint submissions[4] contend for two additions to that order.

32. The first addition sought is that, in effect, paragraph 1(a) be expanded so that the prohibition on publication apply not just to:

> patient records, medical records and clinical records of patients of (the BAC) including "Health Information" under the *Information Privacy Act* 2009 (Qld) and 'confidential information' under the *Hospital and Health Boards Act* 2012 (Qld).[5]

but also to:

- information under the *Disability Services Act* 2006;
- information subject to Chapter 6 Part 6 of the *Child Protection Act* 1999; and
- personal information under s 426 of the *Education (General Provisions) Act* 2006.

33. There is a problem with identifying '*information*' under the *Disability Services Act* 2006. That Act deals with a number of different types of '*information*' such as '*investigative information*', '*police information*', information from the DPP, information from the Mental Health Court and various other bodies, information to be given to a guardian, information about the use of restrictive practice, misleading information, information about criminal history and '*particular information*'.

34. Section 228 uses the concept of '*confidential information*' but that is not specifically defined. Instead, confidential information is:

(a) information not referred to in s 227 (e.g. criminal history);

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4 Joint Submissions of State of Queensland, West Moreton Hospital and Health Service, Metro South Hospital and Health Service, Metro North Hospital and Health Service relating to confidentiality and closed hearings dated 21 January 2016.

5 The relevant definitions for the two legislative provisions referred to in the present order are extracted in Attachment 2.

(b) information gained through the involvement of the Act's administration.

35. The definition of confidential information in the dictionary at the end of the Act is '*inclusive*' in the sense that it includes information about a person's affairs, but not information already publicly disclosed or statistical information.

36. Given that clarity is needed in the order (it may be referred to by media representatives or the general public) it is difficult to see how a reference to the *Disability Services Act* 2006 should be incorporated. And, if it were to be added, what would it add to the existing prohibition?

37. Chapter 6 Part 6 of the *Child Protection Act* 1999 protects the confidentiality of notifiers of harm or risk of harm, and it restricts the use of that information. It is difficult to see how those provisions are relevant here.

38. Section 426 of the *Education (General Provisions) Act* 2006 provides that Education staff, who obtain personal information about a student, are required not to make a records of that information or use or disclose the information other than as permitted by the Act. For the purposes of the section, '*personal information*' means '*information or an opinion*', whether true or not, about an individual whose identity is apparent, or can reasonably be ascertained, from the information or opinion.

39. There is no clear definition of '*information*'. The plain object of the Act is to ensure that staff do not disclose personal information about their students, unless authorised to do so.

40. The purpose of the Commission's order is to, with clarity, prohibit the publication of patient health information and information that will identify a patient. That purpose is not assisted by adding further, different concepts of confidentiality enacted for different purposes.

41. It is difficult to see how the existing order can be improved by reference to the *Disability Services Act*, the *Child Protection Act* or the *Education (General Provisions) Act*. Those provisions are specific to the special circumstances in those Acts.

42. It can be conceded that there is some legitimate interest in including educational information as information that may not be published. However, already information which identifies a patient of the BAC is comprehended by the order.

43. A more general point is that clarity is important. It may not assist the clarity of the order to require a person to analyse five different pieces of legislation in order to assess whether a proposed publication is prohibited or not.

Variations to Order – Further Words in 1(b)(i)

44. Paragraph 1(b) prohibits the publication of evidence that:

> (i) *identifies, or is likely to lead to the identification of a patient or former patient or their family.*

45. To that sub-paragraph the joint submissions contend that the Commissioner should add these words:

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

46. The existing provision prohibits publication of any evidence that identifies or is likely to identify the patient or family.

47. The suggested addition lists some examples of information that might lead to identification of the patient or family. In a sense, the addition does not seek to broaden the order but seeks to provide examples of identifying information. Those examples are not intended to be exhaustive – see, the reference to '*anything else*'.

48. However, the suggested addition might lead to a person to conclude that identification of the gender or diagnosis (e.g. '*a number of female patients suffered eating disorders*') was contrary to the order.

49. As it happens, because of the cooperation of the parties and Commission staff, the Commission's confidentiality processes are redacting identifying information in a multitude of situations. For example, references to a particular place in Queensland are being excised because only one patient came from that place. References to receiving services are often being redacted.

50. On balance, counsel assisting prefer the clarity of the existing order on this aspect and are a little concerned that adding examples of specific identifying material may simply add confusion.

Variation to Order – Further Words in 1(b)(iii)

51. The joint submissions suggest the addition of the underlined words below to paragraph 1(b)(iii) of the order:

> (any evidence that) *contains details of the method or location of any incidents of self-harm* (must not be published…)

52. The addition of those words is a sensible suggestion. A reference to the details of a location of such an incident has a risk of '*copycat*' behaviour.

53. In particular, Professor John Allan's report refers to the evidence that '*explicit descriptions of methods and places of suicide have led to increased suicide risks*'.

54. Our preliminary view is that the amendment should be recommended.

Variation to Order – Protection for Staff

55. At the hearing on 15 October 2015, Counsel for the State tendered a letter by Dr Stephen Stathis dated 9 October 2015.[6]

56. That letter raised a further issue, namely whether Queensland Health staff deserved some confidentiality protection during the hearings.

57. No substantive submissions have been received in support of that contention. The joint submissions foreshadow[7] that the applicants will provide individual submissions, to the

[6] It is Exhibit 1.
[7] Para 26

extent considered appropriate, on that issue. None have been received. It is important for the Commission, and the parties to know whether there is a live issue and what is being proposed.

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