In the matter of the *Commissions of Inquiry Act 1950*
Commissions of Inquiry Order (No.4) 2015
Barrett Adolescent Centre Commission of Inquiry

AFFIDAVIT

Beth Kotzé, Director of Mental Health – Children and Young People, 60 - 62 Victoria Road, Gladesville, New South Wales states on oath:

1. In this affidavit, former patients of the Barrett Adolescent Centre will be identified using the following codes:

2. **Exhibit A** to this affidavit is a copy of my current curriculum vitae.

3. I was seconded to the New South Wales Ministry of Health into the position of Associate Director – Health Systems Management, Mental Health and Drug and Alcohol Office from 4 November 2013 until 4 November 2014, and then extended until 19 December 2014. I then took leave and returned to my substantive position in February 2015.

4. In my substantive role I am responsible for a multidisciplinary team that leads the development of and supports the implementation of specialist mental health services and programs for children and young people with mental health problems in New South Wales. The Unit, Mental Health-Children and Young People ("MH-CYP"), is

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responsible for leading and supporting the development of mental health services and program redesign to improve the quality and safety of mental health services for children and young people and their families, including the use of outcome measures, reflective practice and evaluation in the routine work of clinical services.

5. This work involves the development and maintenance of strong collaborative relationships with young people and their families, clinical services, key government and non-government agencies, consumers and carers, and community organisations. The major areas of activity of the Unit encompass service development, planning and projects, benchmarking of clinical services for improved performance, clinical policy development, development of tools and resources to support workforce competency, progressing interagency and inter and intra-governmental partnerships and specific clinical projects in complex clinical areas.

6. The role of Associate Director – Health Systems Management, encompassed responsibilities pertinent to mental health care service delivery at a State level, including clinical management and policy development, representation at State and Commonwealth forums and negotiation at a senior level with State and Commonwealth agencies and private entities. A major area of responsibility during my secondment was the review of the *Mental Health Act (2007)* NSW.

7. I have been a fellow of the Royal Australian and New Zealand College of Psychiatrists ("RANZCP") since 15 October 1988. I have subspecialty qualifications in child and adolescent psychiatry obtained in 1990, and in psychoanalytic psychotherapy obtained in 1991. I hold the degree of Master of Health Administration obtained from the University of New South Wales in 1999. I am a fellow of the Royal Australasian College of Medical Administrators (RACMA) admitted in 2000.

8. I am a professional senior colleague of Drs Bill Kingswell and Dr John Allan. Dr Allan was previously the New South Wales Chief Psychiatrist. I am an active member of a number of committees and working parties of the RANZCP and RACMA. As a result I have professional collegial relationships with a considerable number of psychiatrists based in Queensland. To the best of my knowledge this does not include Drs Brennan and Sadler, both of whom were former Clinical Directors of the Barrett Adolescent Centre. I first met Dr Brennan and Dr Sadler in person in the process of writing my

report into the transition of consumers from the Barrett Adolescent Centre. Neither of them are involved in any committees on which I sit.

9. I was appointed a Secondary Investigator by the Sunshine Coast Hospital and Health Service on 4 March 2014 in relation to an entirely separate and unrelated matter.

10. I have subspecialty qualifications in child and adolescent psychiatry obtained in 1990, and throughout my career I have worked in a number of senior clinical, management and leadership positions as outlined in my CV.

11. I further state that in relation to transitional planning for youth mental health care, this has been a longstanding professional area of interest, driven by my experience of the critical importance of this period of clinical care and the difficulties that young people experience in transitioning between phases and types of clinical care and across service boundaries. I avidly follow the academic and other available literature. I have been active in initiating targeted clinical practice improvement projects since the early 2000s and more recently I have initiated ongoing activity by MH-CYP in this area that includes continuing to source up to date information and literature.

12. An example of a specific workforce development activity in the area of transitional care is that in 2012 as Director of MH-CYP, I sponsored a key event for clinicians to share their experience and knowledge of models of transitional care that work with a visiting international expert. **Exhibit B** is a flyer from this event which included a speaker from Queensland who was sourced to show-case useful clinician-led thinking in relation to transitional care. Other examples of workforce development where I have been involved in promoting evidence-based transitional care have been through my involvement as the expert representative of the RANZCP in the development of MH-POD (Mental Health-Professional On-line Development) which is an on-line workforce development resource for clinicians in the first two years of active practice in mental health and the involvement of my team in state and national mental health workforce competency initiatives.

13. The term 'transition planning' in adolescent mental health is used to refer to adolescents transitioning from child and adolescent to adult mental health services at age 16-18 years. The term is also often used in everyday language as synonymous with discharge and transfer of care of young people irrespective of their age between services or service components (for example, transfer from inpatient to community-

based care). Common across these scenarios is the need to take into account the young person's developmental stage and their relative maturity in regard to how they are managing their health. A straightforward example is the impact of the young person's developmental maturity on their attitude towards keeping appointments with health professionals. Young adolescents are more likely to rely on their parents/families to ensure that they are brought to appointments with health professionals; whereas it is an expectation that adults will self-manage such appointments. In the transition from adolescence to adulthood, there is the expectation that young people will increasingly be able to manage their own health behaviours. However they are often reluctant to keep office-based appointments with health professionals so they may require a level of support that decreases over time. In general, transitional care planning is informed by an understanding of the developmental stages of adolescence and how adolescent health behaviours develop over time as the young person matures; an evolving literature; a philosophy of care that recognises that the young person is striving towards autonomy and balances this with the age-appropriate continuing involvement of their family in their care; and values such as respect for the young person's developing sense of autonomy in decision-making and seeking to engage the young person in their preferences for care.

14. I have had no prior involvement in the operation and management of the Barrett Adolescent Centre. I knew of the Centre's existence. I do recall hearing about the unit during the development of the Draft National Planning Framework for Mental Health Services in either 2012 or 2013. My recollection is that the unit was considered to not operate a contemporary model of care as it offered long-term residential care in an institutional setting.

15. At some stage during this period I recall that a colleague in New South Wales was contacted by Dr Sadler, whom I understand was the Director of the Barrett Adolescent Centre at the time. That colleague put Dr Sadler in touch with me. I recall Dr Sadler contacted me by telephone. My recollection of the conversation is vague. Dr Sadler was concerned that the kind of long-term residential care that the Barrett Centre provided would not be included as a contemporary model of care in the Draft National Mental Health Services Planning Framework. I suggested to him that he contact the Queensland representatives involved in the process. I have no idea if this occurred and had no further contact with Dr Sadler at that time.

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16. I recall sometime around that conversation seeing a breaking news story in the electronic media about a nurse having been stood down from the Barrett Adolescent Centre

17. I recall being asked by a New South Wales colleague as to whether New South Wales and Victoria operated similar inpatient units to the Barrett Adolescent Centre. I am not aware of how the timing of this query compared to what was happening at the Barrett Adolescent Centre. I know that there are 2 units in NSW that offer non-acute non-declared inpatient care for young people on a 4 night per week school-term basis with co-located hospital schools. There is a sub-acute unit declared under the *Mental Health Act (2007)* NSW that offers medium-term care to young people with severe and enduring or treatment resistant mental illness. There are youth step-up step-down models of care in Victoria operated by the non-government sector.

18. The model of care of the NSW units emphasises integration of the young person into their home school (or alternative vocational service) and ensuring connectedness to family, peer and community relationships. This approach aims to maximise the potential for the young person to recover from their mental health issue and to participate in society. This approach reduces the risk that the young person will become institutionalised as a result of prolonged inpatient admission and separation from key relationships with family, peers and community and reduced opportunities for normal development in normalising environments. Institutionalisation creates the risk of enduring or even life-time disadvantage through disruption to a young person's functioning and psychosocial development.

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

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20. 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.

Engagement to provide the report

21. The background of my becoming involved in the report into the Barrett Adolescent Centre is as follows:

(a) I was contacted by Dr Bill Kingswell on or about 7 August 2014 via mobile phone. My recollection is that we discussed, in a preliminary way, the feasibility of me being involved in an investigation and preparation of a report into the transition care for adolescent consumers at the Barrett Adolescent Centre. At the time, I had a period of planned, imminent overseas leave. I did not retain any record of that conversation. I recall that at that time, Dr Kingswell also advised that the investigation would be supported by a lawyer in Brisbane. That support on-the-ground in Brisbane was essential to me as it made the prospect of being involved in the preparation of the report related to an inter-state service within a tight time-frame a feasible undertaking.

(b) By email dated 11 August 2014 at 9:17am, I provided to Dr Kingswell at his request, a brief curriculum vitae. It was an abridged version setting out my clinical and service related experience and qualifications. **Exhibit C** to this affidavit is a copy of that email and my abridged CV that was submitted to Dr Kingswell.

(c) **Exhibit D** to this affidavit is a copy of an email from Wensley Bitton dated 14 August 2014 at 5:06pm attaching my appointment as an investigator, the terms of reference and other documents.

(d) I recall advising Dr Kingswell that the timeframe he proposed to me was tight, but would be achievable.

(e) I did not know Ms Geddes, who was the lawyer providing assistance prior to this time, and had not heard of her. I am the line manager of Ms Skippen. At that time, I was on a secondment, and Ms Skippen reported to the person acting in my position.

(f) Dr Kingswell had asked me to nominate a non-medical co-investigator for the report, and I nominated Ms Skippen, who is an occupational therapist. **Exhibit E** to this affidavit is the timeframe emailed to me by Dr Kingswell on 8 August 2014 at 4:00pm.

22. The clear expectation at the outset was that the investigation team would produce one report. **Exhibit F** to this affidavit is a copy of our report dated 30 October 2014 (including Annexures A – D).

23. Upon receipt of the Terms of Reference and Instrument of Appointment, contact was initiated between myself, Ms Skippen and Ms Geddes on 18 August 2014 to progress the development of a coordinated approach to the investigation. **Exhibit G** is a copy of an email exchange between Ms Geddes and I on 18 August 2014. **Exhibit H** to this affidavit is a copy of an email from Ms Geddes to Ms Skippen and I dated 25 August 2014 at 11:40am. In this email, Ms Geddes stated that she had proactively developed a draft framework for our investigation and report.

24. I recall that Ms Geddes indicated to us that she would provide a copy of the investigation plan to Queensland Health, and would also advise Queensland Health that the original timetable was not feasible. This ultimately resulted in the revised time frame being provided by Queensland Health.

25. I then recall that on 28 August 2015, Ms Geddes contacted me regarding my availability to travel to Brisbane to commence a review of the documentation.

26. It is part of my standard approach to a review of this nature that I would refer regularly to the Terms of Reference throughout the process including at the stage of planning an approach, during the process when more information is being gathered and during the process of preparing the report. In undertaking other work like this, I have had no hesitation in raising issues relating to the Terms of Reference, such as matters of interpretation and scope, with the commissioning agent. –.

27. Ultimately, there was an adequate division of labour, and Ms Geddes' role proved to be invaluable in organising the documents, recording interviews, arranging transcripts undertaking a direct component of the investigation work related to the governance review; and managing the mechanics of the investigation process. I did not ask Ms Geddes if she had been involved in any earlier investigation of this nature.

28. A penultimate draft report was provided to Ms Geddes on 27th October 2014. Ms Geddes provided feedback on formatting, presentation and content. The feedback was considered by Ms Skippen and me. The majority of the feedback was accepted with the exception of a recommendation in relation to content.

29. As details of the volume of material that would need to be considered emerged, Ms Skippen and I reviewed the extent of the task in the context of the periods of leave that we both had planned, and we divided up some of the key tasks between us. For example, I travelled to Brisbane and spent a day reading the entire available material, which was in excess of 30 lever arch files located at Ms Geddes' office, without Ms Skippen being present. When Ms Skippen returned from leave, she travelled to Brisbane and prepared detailed clinical summaries for the key consumers.

30. While there was a sketched outline of the method developed by Dr Kingswell to guide the investigation at the outset (which was subsequently revised as it became clear that the initially proposed timeframes were not feasible), it was also clear that the progress of the investigation was highly dependent on completion of the review of the documentation and the progress of the interview schedule. The interviews could not be completed until after the review of the documentation had been completed.

31. Initially Ms Skippen and I considered undertaking the interviews independently to expedite the process. However ultimately we considered it more desirable to undertake the interviews together to facilitate a multidisciplinary understanding of the clinical issues. That approach also allowed us to positively manage the interactions with clinicians, who we expected would find the process stressful. Ms Skippen and I undertook the interviews of key clinicians together. We shared observations and conclusions. We identified additional information required to obtain a comprehensive understanding of the issues. We cross-checked data gathered in our reviews of the documentation and at interview.

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32. The intensity of our contact in relation to the review varied during the process. It was intermittent during the early stages, but increased as readiness to prepare the report was achieved. In the final stages of the preparation, we worked together intensely on more than one day in the workplace. We prepared the report as a team, working iteratively and literally together in front of a computer to complete the report.

33. A local person on the ground was essential to coordinate and facilitate the process and gather necessary information. Ms Geddes had a pivotal role in:

(a) organising collection of materials;

(b) scheduling interviews;

(c) organising transcripts of interviews;

(d) providing a draft proposed proforma for the investigation and report;

(e) summarising in tabular form the extensive documentation that was considered during the review;

(f) undertaking a component of the report preparation pertinent to governance; and

(g) undertaking ongoing liaison with Queensland Health on issues that arose during the investigation. For example, the matter of interviewing parents/families of former consumers was discussed by email and on at least two occasions in person. Ms Geddes undertook to discuss this issue with Queensland Health. I recall her indicating that there was concern about us interviewing the families given the anticipated Coronial Inquests and the possibility that the families might be distressed by interviews. I understood that this concern was shared by Ms Geddes and Queensland Health.

34. My strong view at that time was, and remains, that it would have been more desirable to include interviews with the parents/families in the investigation process. I considered that there would be an expectation by the parents/families that this would occur. Early in the process, I also considered how Term of Reference 3.1.2 could be addressed and raised the matter of interpretation of this Term of Reference with Dr John Allan and Ms Geddes. I recall that Ms Geddes expressed concerns about us interviewing the families and undertook to discuss the matter with Queensland Health. After reviewing the very comprehensive documentation and conducting the interviews we indicated that we could address this specific Term of Reference. If I had come to the conclusion that we could not address this Term of Reference, I would have drawn this

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to the attention of Dr Kingswell or Dr Allan. After reviewing the documentation and interviewing clinical staff, we concluded that there was evidence that the biopsychoscial needs of the consumers and parents/families were identified comprehensively by the clinicians and comprehensively planned for.

35. I also recall Ms Geddes providing an updated Framework for Investigation/Report, which included flow charts illustrating the governance structures and details of further discussions she had with key personnel from the West Moreton Hospital and Health Service.

36. I received no remuneration for the preparation of the report. I was however reimbursed my expenses while away from home.

37. **Exhibit I** to this affidavit are copies of earlier drafts of the report prepared by Ms Geddes, Ms Skippen and me and copies of the email exchanges regarding the revision and feedback provided.

38. **Exhibit J** to this affidavit is a copy of a letter from the Director-General of Queensland Health dated 28 August 2014 by which the date for provision of our investigation report was extended.

39. There was only one Instrument of Appointment and Terms of Reference (**Exhibit D**). The date for the delivery of the report was extended when it became apparent that the initial timeframe would not be met for a variety of reasons, in particular the large volume of documentation received, the potential number of witnesses and the leave which Ms Skippen, Ms Geddes and I had previously arranged. Ms Geddes provided a proposed extended timeframe in her email of 25 August 2015 at 2:08pm. **Exhibit K** to this affidavit is a copy of that email.

40. As one of the three appointed investigators, Ms Geddes sourced and then provided to Ms Skippen and me, extensive documentation at the outset of the investigation and then further documentation during the process of the review. As stated earlier in this affidavit, that material exceeded 30 lever arch folders.

41. A summary of that material was annexed to the report as Appendix A (**Exhibit F**).

Preparation of the Report

42. The roles of Ms Geddes, Ms Skippen and myself in the investigation process, is set out in paragraphs 23 – 40 above. I am unable to identify a meeting which occurred between Ms Geddes and I on 4 September 2014. I travelled to Brisbane on 5 September 2015 to commence the hard copy documentation review at Ms Geddes' office.

43. I made no direction to Ms Geddes as to her role in the investigation and reporting process.

44. The processes and methods I undertook to investigate and make the findings and recommendations contained in the report included a review and analysis of documentary evidence and interviews with key identified clinicians and discussion between the investigators to consolidate the findings into a single report.

45. The key materials are set out in Appendix A to the report (**Exhibit F**).

46. Each element of the information was considered for its place in the jigsaw puzzle in order to obtain as comprehensive and complete an understanding of the issues as possible. No particular document was more influential. As is usual in these types of review, when multiple sources of data appear to confirm consistency in experience or understanding of issues or events, then some weight of significance was attached. For example:

    (a) The clinical documentation for individual consumers, documentation of clinical incidents, interviews with clinical staff and email correspondence, depicted a consumer cohort with relatively high rates of responding to stress and distress with active self-harm and in the period of the closure of BAC there appeared to be an escalation in such events.

    (b) The extensive documentation in relation to detailed and careful clinical care planning for the transitional period confirmed in interviews with clinicians and supporting the conclusions in relation to the individualised, holistic and comprehensive nature of the clinical care planning process, the involvement of the young people and their families in the processes and the inter-agency negotiations around referrals and transfer of care.

47. In the main, it is my understanding that the information requests were initiated at the outset by Ms Geddes. The entities that provided the information are listed in Appendix A of the report, the investigation document index (**Exhibit F**). The extensive documentation was made available to Ms Skippen and me by Ms Geddes at her office and in soft copy. As I recall the quantity of material reviewed by Ms Skippen and me was in excess of 30 lever arch folders.

48. Some supplementary information was requested by me and Ms Skippen as the investigation proceeded. For example, statements of duty of the care coordinators (which were useful in establishing the clinical context); a copy of the 2008 Barrett Adolescent Centre review (this review may have been potentially useful in further understanding the history of the Barrett Adolescent Centre approach to transitional care planning because of the practice of extended inpatient admissions; unfortunately this was not provided however it was not critical to the production of the final report). When additional information was sought, the request was made by me or Ms Skippen to Ms Geddes, who followed through.

49. Doctors Brennan and Sadler provided self-initiated documentation in emails and in person at their interviews.

50. Dr Brennan provided an unsigned written statement to Ms Geddes by email on 10 October 2014 at 3:11pm prior to her interview. **Exhibit L** to this affidavit is a copy of this email attaching the unsigned statement. Dr Brennan provided a signed version to Ms Skippen and me at her interview with us on 13 October 2014. I no longer have a copy of the signed statement. I believe that I left that document at Ms Geddes' premises following the interview as it formed part of the relevant documentary evidence for the report. On 15 October 2014, Dr Brennan provided, via her lawyer, an email with some additional information. **Exhibit M** to this affidavit is a copy of that email dated 15 October 2014 at 9:04pm.

51. Ms Geddes conducted an initial review of the material and identified the preliminary list of clinicians to be considered for interview. The list was progressively narrowed after the detailed review of the clinical files by Ms Skippen and me. Ms Geddes undertook the contact and scheduling of interviews with the clinicians and their support persons. The final interview schedule reflects the clinicians whom we deemed necessary to

interview and who were both agreeable and available to be interviewed. The meetings were arranged by Ms Geddes at her office premises and scheduled over two days. I recall that we interviewed 12 individuals. A list of these individuals appears at Appendix B of the final report (**Exhibit F**).

52. The interviews took place on 13 and 14 October 2014. The interviews were recorded, but I understand that the transcripts were not reviewed, corrected or approved by the interviewees as would be expected should the transcripts be made available for use other than the narrow purpose of the preparation of the investigation report. Hence, in the interests of natural justice, the interview transcripts were not appended to the final report. **Exhibit N** to this affidavit are copies of the interview transcripts.

53. The framework for the nature and scope of the investigation was determined by the Terms of Reference. During the investigative and review process, additional documents were sourced on request to Ms Geddes. Ms Geddes consulted consistently in the organisation of the interview schedule. Ms Skippen and I were not at all constrained as to the questions to be asked.

54. I understand Ms Geddes consulted with Queensland Health in relation to, for example, the interviewing of parents/families. I refer to my email to Ms Geddes of 10 September 2014 at 11:34am, a copy of which is **Exhibit O** to this affidavit. It is my understanding based on verbal feedback from Ms Geddes that there was a concern in relation to us interviewing the families because of anticipated Coronial proceedings and the potential to cause distress. However, after considering the detailed and comprehensive documentation care planning and the interviews with clinicians, we were able to address Term of Reference 3.1.2 in the report without interviewing those families.

55. Ms Geddes was the key contact between us, as investigators, and Queensland Health. If we required any documents, we would request that Ms Geddes obtain those from Queensland Health. To the best of my recollection those documents were provided.

56. Dr Sadler emailed Ms Geddes twice on 22 October 2014. Ms Geddes forwarded the first email from Dr Sadler to me on 22 October 2014 at 8:40am. **Exhibit P** to this affidavit is a copy of this email and its attachments.

57. On 22 October 2014 at 11:26am, Ms Geddes forwarded me a second email from Dr Sadler which was sent to her earlier that same day. **Exhibit Q** to this affidavit is a copy of this email and its attachments dated 22 October 2014 at 11:26am. I cannot recall receiving, and cannot identify in my records, any email from Dr Sadler, or any other senior clinician from the Barrett Adolescent Centre, dated 21 October 2014.

58. **Exhibit R** to this affidavit is a copy of a letter from the Metro North Hospital and Health Service to Ms Geddes dated 28 October 2014. I am unaware of the content of, and the circumstances in which, a letter was sent to Metro North Hospital and Health Service prior to that letter.

59. **Exhibit S** to this affidavit is an indexed copy of the published literature which Ms Skippen and I considered when investigating and writing the report.

60. My experience and qualifications in adolescent mental health are outlined in my curriculum vitae which is **Exhibit A**. I remain up to date in the field as a clinician, a member of various relevant workforce and service development committees, and as an active member of the Faculty of Child and Adolescent Psychiatry, and other committees of the RANZCP, and through attending National and State conferences and through collegial networks and review of the Australian and international literature.

61. Recent examples of examining the practise of adolescent mental health care in other jurisdictions include:

    (a) In 2013 I reviewed the non-acute inpatient units in New South Wales with a colleague, Dr Titia Sprague. As part of this process, the contemporary literature on non-acute inpatient service provision for adolescents (and children) was sourced and advice was sought from other jurisdictions and internationally (New Zealand and the UK) as to current practice in this mental health service element;

    (b) Earlier this year, I undertook a review of the Orygen Inpatient Unit Victoria, an acute youth mental health inpatient unit;

    (c) In 2012-2013, I was a New South Wales representative in the process of the development of the draft National Mental Health Service Planning Framework.

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Approximately 200 experts from across Australia met over a period of more than two years to progress the development of a National decision support tool to support planning for the provision of mental health services across all age groups across a population. This process brought together clinicians, managers, consumers, carers, non-government organisations, academics, researchers and technical, financial, epidemiological and planning experts in a comprehensive process that examined literature and databases in relation to service elements, service utilisation and best available treatment evidence.

The outcome was a taxonomy for agreed service elements in a comprehensive mental health service system and a tool that assists with planning at different levels in the system (for example, at local, district or State level) for different service elements (for example, day patients, inpatients etc) for each of the different age groups. It is built up from predictions in a population as to the prevalence of mental health disorder/illness, the evidence supporting interventions and the care packages required by consumers. This process involved a comprehensive understanding of the service elements currently provided in the jurisdictions and expert agreement by consensus on what and how much should be provided in an 'ideal system'.

As part of this process, I furthered my comprehensive understanding of the practice of adolescent mental health care in other jurisdictions. Further, my team developed the New South Wales bid for the Early Psychosis Prevention Intervention Centre Development (Commonwealth funded) based on the work of Professor Pat McGorry from Victoria. The preparation of the bid involved extensive examination of youth/adolescent mental health literature and an understanding of youth mental health service models in Australia.

62. By reviewing in excess of 30 volumes of material, and interviewing clinicians, Ms Skippen and I were able to obtain an understanding of the information which was and was not available to clinicians and staff between 6 August 2013 and January 2014. For example, the Communication Strategy, Communication Plan, Stakeholder Engagement Plan and examples of the BAC staff communiqué gave us a good understanding of the information that was available to clinicians and staff.

63. The desirability of interviewing the agencies that received the referrals of consumers leaving the Barrett Adolescent Centre was identified early in the process. **Exhibit T** to this affidavit is a copy of my email to Ms Geddes dated 8 September 2014 at 5:24pm in which I raise this issue. **Exhibit U** to this affidavit is a copy of the email response from Ms Geddes dated 9 September 2014 at 7:56am in which she indicates that in the interest of time she questions whether it will be possible to obtain the information we require from these receiving agencies via information requests rather than interviews.

64. **Exhibit V** to this affidavit is a copy of my email to Ms Geddes dated 10 September 2014 at 11:34am indicating the type of information that might be required from those agencies. I received a response from Ms Geddes on 23 September 2014 at 4:19pm indicating that she had now received responses from all of the receiving agencies for the six complex consumers (included in **Exhibit V**).

65. Senior Nurse Vanessa Clayworth declined to be interviewed on medical grounds. On 13 October 2014, Ms Geddes advised me and Ms Skippen that she had received an email from the Australian Workers' Union on Ms Clayworth's behalf advising that she would not be attending the interview due to medical concerns [redacted] The reason for the request for the interview was the same as for interviewing any other witness, that is, to address the issues set out in the Terms of Reference.

66. The documentation was initially read in hard copy. Firstly, everything that was made available was read. It was quickly evident that the clinical files were frequently duplicated, and there were often multiple pages covering the same information with different sections completed. This is not at all unusual in my experience in reviewing clinical files. The method of hard copy review enables efficient processing back and forth between sections, and use of sticky notes to mark sections that need to be reconciled, returned to later or followed up. Both Ms Skippen and I are very experienced in the process of analysing large volumes of complex detail in relation to policy and clinical mental health issues in order to provide prioritised, succinct and clear advice within tight timeframes. This is something that is required of us on a daily basis in our roles.

[redacted] [redacted]

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67. Ms Skippen and I had the opportunity to discuss how to assemble and synthesise the evidence over many conversations conducted in our offices, during travel to and from Queensland and whilst in Brisbane. I further state that:

(a) This resulted in the method of presentation selected as per Appendices A, C and D of our final report (**Exhibit F**):

- Appendix A: Investigation Document Index.
- Appendix C: Transition Planning Evidence Checklist.
- Appendix D: Client Profiles and Transition Planning Evidence Summary.

(b) Our referring evidence folders for drafts of the report and my brief aide-memoirs produced during the review process were not retained once the report was finalised with the single exception of a table of inpatients and day patients of the Barrett Adolescent Centre (with handwritten notes), a copy of which is **Exhibit W** to this affidavit.

(c) This process of assembly then enabled us to analyse and discuss the data so as to reach a consensus view on the conclusions.

(d) I cannot recall any divergence in our views and the discussions were extremely helpful in that the discussions left me, and, as I understand it Ms Skippen, feeling confident that we had captured exactly what we believed to be fair and justifiable conclusions. My recollection is that our discussions related to the scope of the conclusions and then the nuances of wording of each conclusion to ensure that we were quite clear and precise in our written communication in the final document.

68. When we use the term 'expert clinical review' in our report, Ms Skippen and I were referring to our own review of the material, Ms Skippen and I both being qualified health professions with relevant formal qualifications and clinical experience in a similar health service environment.

69. That term, 'expert clinical review', was not used by us in contemplation of Part 6, Provision 3 of the *Hospital and Health Boards Act 2011*.

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70. The six clients referred to in the reports as patients to were as follows:

71. The content of the transition plans is summarised in Appendix D of the report and referenced to the relevant Queensland Health policy in existence at the time in Appendix C, a copy of which is **Exhibit X** to this affidavit.

72. Appendix D, Client Profiles and Transition Planning Evidence Summary, provides a brief dot point review of each of the clinical records in relation to the six consumers. The individual summaries succinctly record the key clinical data and contextual factors pertinent to comprehensive clinical care planning and provide a narrative overview of the transitional planning process for each consumer. In essence this is the content summary of what was in the clinical case records (**Exhibit F**).

73. Appendix C is the next level of analysis where the content of the files was aligned with the key transfer of care principles in the Queensland Health policy plus two additional considerations that the reviewers identified in the process as key requirements for some consumers, being brokerage funding and sourcing of additional supports. This provides a ready guide to the overall provision of transitional care for the clients in alignment with the state standard.

74. The transition plans of all consumers were considered in the review of the documentation. For the purposes of the report a sample of consumers was selected based one or more characteristics, being:

(a) known ; and/or

(b) complexity identified in the process of the documentation review; and/or

(c)

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75. I recall seeing a piece of correspondence in one of the first hard copy folders which had the six consumers identified. I can recall that document but I no longer have a copy.

Governance model

76. The formal governance arrangements are described on pages six and seven of the report, identifying the key structures and clear reporting lines, the broad and inclusive scope of membership and delineation of roles.

77. Examples of available documentation include the description provided in the letter from the Chief Executive West Moreton Hospital and Health Service 24th August 2014 which is **Exhibit Y** to this affidavit; the documentation developed by Ms Geddes subsequent to her meeting with officers of West Moreton (**Exhibit H**); and the copy of the Issues Register provided by Dr Brennan at interview, a copy of which is **Exhibit Z** to this affidavit.

78. The statement provided by Dr Brennan confirms that she was the key link between the Barrett Adolescent Centre process and the broader governance structure via the Clinical Care Transition Panel that she chaired and where an issues register was maintained to enable communication of issues and difficulties. The Barrett Adolescent Centre team led by Dr Anne Brennan was responsible for the development of Individual Transition Care Plans for the consumers.

79. It is my view, based on the documentation and interviews, that Dr Brennan provided clear, visible and personal leadership throughout the process, including supervision of other staff, direct involvement in complex cases and she ensured proper care planning processes and documentation.

80. I also formed the view that Dr Brennan had a proactive approach to actively identifying what was happening for the consumers, dealing with the issues in care planning and communicating this through the governance process. There were examples of Dr Brennan actively engaging with concerned parents and families to assertively deal with complaints and concerns.

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81. In essence, I formed the view that the governance processes and structure did support a patient-centred and quality of care approach that was most strongly realised the closer one moved to the clinical processes and interactions. That is, that the central area of concern was at the level of interaction of the clinician and consumer, and the appropriate expectations and culture were promulgated and led by Dr Brennan. The formal governance structures provided a framework and mechanism for actively advising up the hierarchical system in relation to issues and difficulties and practical problem-solving assistance when this was required and possible. For example, where required, via formal governance process, additional brokerage funding to support transitional care was available.

82. At the level of direct clinical care to consumers, the approach was open and transparent. There was a strong value of accountability to the consumers and involvement of consumers and families in care decisions where possible. Complaints were responded to promptly and the care provided was reliable, empathic and responsible. These are features of a functional clinical governance system in action, albeit under very difficult circumstances.

Transition arrangements

83. The published literature provides guidance and principles in relation to transitional care for young people with mental health issues. There are technical and non-technical aspects to transition care.

84. Technical aspects include:
    (a) the assessment of clinical needs; and
    (b) planning for clinical care (i.e. medications, physical health care needs, Crisis Care Plans, etc).

85. Non-technical aspects include:
    (a) a relationship between the clinicians and services and the young person and their family;
    (b) the values and philosophy of care that seek to empower the young person in making choices in their lives and care and instil hope for their future; and

(c) the functionality in the multidisciplinary team and inter-system relationships that promote good collaboration and consistency in care across treatment settings and phases.

86. Both technical and non-technical aspects are important in providing good mental health care to young people.

87. The initial investigation report framework developed by Ms Geddes and provided in her email to me and Ms Skippen on 25 August 2014 (**Exhibit H**), identified all consumers at the Barrett Adolescent Centre as being in scope for review.

88. The care records of all consumers included in documentary evidence were reviewed. This included All consumers were considered, and their records included clinical records and Transition Plans as at 6 August 2013.

89. The adequacy of the Health Care Transition Plans was appraised on the basis of consideration of the clinical data, the documentation of comprehensive multidisciplinary specialist assessments (for example, medical, occupational therapy), the synthesised holistic care plans that considered comprehensively the biopsychosocial needs of the consumers and evidence of the implementation, including problem-solving to achieve required level and type of post-discharge care.

90. The appropriateness of the Health Care Transition Plans was appraised on the basis of consideration of the alignment of the care assessment, planning and implementation, including evidence of a young person's involvement in decision making. To assist, we used the summary outlining the clinical documentation that we had considered, which is set out in Appendix C to the report.

91. Our use of the term 'atmosphere of crisis' was used after considering the clinical documentation, incident reports and interviewing staff and the supporting statements provided by Drs Brennan and Sadler.

92.

93.

94. I formed the impression that prior to the closure announcement, the Barrett Adolescent Centre was an intense, high-emotion environment where young people formed intense relationships with each other and with staff; a somewhat positive feature of the environment but with drawbacks. It was evident from the clinical files that a number of the young people at the Barrett Adolescent Centre

95. It is not surprising that the standing down of Dr Sadler, the announcement of the closure and the general reaction of staff, consumers and families would give rise to distress and anxiety,

96. I can also state as follows:

(a) It is not possible to quantify the relative contribution of the closure to the atmosphere of crisis;

(b) It is not possible to quantify the relevant contribution of the impact of the standing down of Dr Sadler to the atmosphere of crisis.

97. In my view 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

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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 manage the impact of change on the workforce, such as the provision of information in written and verbal form. All of that said, I do not believe that one can draw a conclusive causal link between the atmosphere of crisis and time-distant consumer outcomes in the context of care being provided by other services.

98. An ideal process of transition would see the date set for each individual based on their individual concerns and issues, and their response to the process of transition.

99. This can be a complex process particularly for some young people who may have developed intense and dependent relationships on the staff and other consumers in an inpatient setting, and who may have undergone some degree of a process of institutionalisation that can occur in prolonged admission to an inpatient setting.

100. The process of the young person leaving a family or home, or even a hospital, may take some time and have several false starts. As I understood it, the date for closure was set as an administrative decision and in expectation of the process of transition being completed over five months or so. It was 'artificial' in the sense that it was arbitrary across a cohort rather than personal to the individuals.

101. In the report, we made the finding that the activities referred to in the last dot point on page 10, were best-practice in transitional care. I came to that conclusion as the examples of activities provided in that dot point were consistent with current evidence-based best practice as described in the published literature. This was my finding based on my review of the documentary evidence and the data gathered at interviews and referenced to my up to date appraisal of the literature.

102. Ms Skippen and I identified that it might have been potentially useful to obtain a time-trended report that graphed reported incidents over time, and in particular before and after the standing down of Dr Sadler and the announcement of the closure of the Barrett Adolescent Centre. Such a report should be expected to be routinely available because reports of that nature are part of the standing clinical governance processes of mental health services and are routinely required for accreditation purposes. However, what was provided was raw incident data for the period after the announcement. It was not

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possible within the time constraints to issue a supplementary request for time-trended incident data for the unit before and after the announcement.

103. The PRIME reports have not been cross-matched with the individual clinical files to establish that all incidents recorded in the clinical files had been captured in the formal incident reporting system. It is superficially understood that the standing down of Dr Sadler had some relationship to incident reporting practices on the Unit. It is not known if this was significant in changing incident reporting practices on the Unit before and after the standing down of Dr Sadler. Nevertheless, it is apparent on review of the clinical files that increased incidents can be gleaned in consumers [redacted] This is a predictable clinical scenario and was dealt with in an expert manner by staff.

104. The names of the relevant consumers are provided in the PRIME reports and ward books. **Exhibit AA** to this affidavit are copies of the PRIME reports and ward books.

105. The review did not find evidence that a review of the designated closure date was indicated to improve the transitional care. As noted in the final dot point on page 9 of the report, the Transition Plans were thorough and comprehensive. In some instances it was not possible to identify a variety of options for each care domain for each consumer, but in each case at least one reasonable option was able to be identified and matched to a particular care domain. At times, there was considerable delay in settling on the final option but this reflected the considerable work involved in identifying a range of suitable options and working through processes of negotiation with receiving agencies.

Other

106. There was no special meaning to the phrase 'reasonable system of care' other than the dictionary meaning of those words. In the context in which I used the phrase in the report, it was to describe the actions of the Barrett Adolescent Centre clinicians who in my view undertook a process of transitional care through a comprehensive care assessment and planning process.

107. Care Plans were developed within the realms of current, accepted biopsychosocial support and evidence-based treatment and the relevant standard at the time. Those

plans were revised and updated as the process unfolded and reasonable and logical steps were taken to implement the Care Plans.

108. In my view, decision-making drew on the resources and strengths of the multidisciplinary team and the availability of senior expert staff and problems and issues were systematically recorded and referred through the governance structure.

109. In my view, the system of care appeared reasonable. That conclusion is based on my experience and expert knowledge.

110. I do not know the name of the Project Officer appointed to the Clinical Transition Panel. I have not attempted to identify or contact this person as I did not consider the matter of administrative support to the Clinical Care Transition Panel as material to the matters I was investigating.

111. The term 'brokerage funding' may be used to refer to provision of funding that is designated for flexible purposes. It is an available pot of money to be applied to purchase 'needful services' for an individual. It provides a higher degree of flexibility in responding to the changing needs of an individual than more routine methods of funding allocation, and is in addition to the routine or recurrent funding. It is an extremely useful tool in responding to the care issues of young people with highly complex needs who require coordinated inter-agency responses and who may benefit from the purchase of an additional care service for a period of time that they would not otherwise be able to access. Access may be unavailable for a variety of reasons, for example, if the service is not provided in the public system but can be purchased from the private system, or there is not identified recurrent funding available for the required purpose.

112. As I recall it, consumers of the Barrett Adolescent Centre were identified as potentially benefiting from brokerage funding in order to provide additional individualised care in the form of additional nursing and/or non-government organisation support during the transition. I am not aware of an example where brokerage funding was requested and declined.

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113. In the report, Ms Skippen and I described that the transition team would 'go the extra mile'. By this, I meant that the clinicians did not approach their task with a minimalist, mechanical attitude, and rather they persisted in the face of frustrations encountered in trying to identify and secure services for the transitioning consumers.

114. There were many examples of staff clearly continuing to respond sensitively and with care and empathy to the consumers whilst managing their own anxiety and stress. For example, they responded to consumers' distress by increasing proximity, and the clinicians would accompany consumers on orientation visits to the receiving service, to assist with developing a sense of connection and trust. Another example is that Dr Brennan showing exemplary leadership in providing an evening presence on the Unit in order to be with the consumers, evenings being a notoriously unsettled time in adolescent inpatient units.

115. There were some examples of Transition Plan documents being incomplete/missing, however, this was not a major issue. For example, in searching for clinical data by reading the clinical files, sometimes there would be a single document that was copied multiple times and rather than there being one single complete copy, the data was recorded across the multiple copies. In my experience, the reality of reading clinical records, and most particularly for consumers with prolonged inpatient stays, is that you have to read the entire record to understand the complete picture. You cannot simply rely on the narrative report or the proforma standard reports as omissions under standard headings in proformas may nevertheless be covered elsewhere in the narrative notes.

116. In a population, the emotional and behavioural disorders of childhood and adolescence are gradually replaced in youth with the psychiatric disorders of adults. However that process is gradual. Some disorders have greater persistence than others and for many adolescents a definitive diagnosis may only emerge over a period of many years. For many children and adolescents, the clinical picture is a complex admixture of

symptoms, family issues, life adversity, developmental issues, relatively poor community/social support and so on.

117. For adults, patterns of disease and disorder are more clearly captured within diagnostic systems that align with standard approaches to treatment and support. These issues create complexity when transferring young people between child and adolescent, and adult service systems.

118. In generalisation, there is frequently a great deal of plasticity in threshold to acceptance of referrals into specialist community public mental health services that reflects the ongoing dynamic issues of matching demand in a population to the availability of resources.

119. A frequent approach with public mental health services is to define a target group, often characterised as people whose needs cannot be met in the primary care sector, such as people with moderate and severe mental health problems with significant impairment. For Child and Adolescent Mental Health Services this means children and adolescents up to 18 years of age who have complex and severe mental health problems and/or who are high at risk of harm. This includes children with complex social, emotional and/or behavioural symptoms and their families who have severe difficulty in functioning and who would benefit from the resources of a multidisciplinary clinical team.

120. An example would be the young person with an anxiety disorder as a presenting problem on a background of significant developmental difficulties and psychosocial adversity, including family difficulties. They may be considered an appropriate referral for Child and Adolescent Mental Health Services considering the additive impact of these factors, or they may not if the primacy is given to the anxiety disorder in isolation. They may have difficulty accessing an adult mental health service as the primary service provider on the basis of the psychiatric diagnosis alone. In my experience of the complex and multi-problem consumer population, like those admitted to the Barrett Adolescent Centre, there is rarely a single service that would match the consumer's array of needs. It could be debated as to which receiving service is ideally suited to best coordinate the necessary multi-system agency response. [redacted] is an example of the challenges in that regard and finding the right

[redacted]

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type and mix of services, noting that a comprehensive Transition Plan was developed for this consumer.

121. Information pertaining to the role of the hospital school and assessment and planning for ongoing educational/vocational care needs was sourced from the clinical documentation including documented holistic care plans. The information available was comprehensive and detailed and sufficient for the purposes of preparing the report. I did not consider it necessary to interview the school staff. That was also a collaborative decision. The decision to proceed on the basis of the provided documentation was collaborative and we were all involved in making it.

Other information and knowledge

122. I have maintained an active professional interest in the area of transitional mental health care of adolescents for a substantial period of my professional career. This interest extends to ensuring that I am up to date in relation to international developments and literature.

123. Keeping up to date with this literature requires scanning alerts of professional journals, attending conferences at which new programs and their evaluations are presented, participating in clinician networks such as the International Initiative for Mental Health Leadership and informal mechanisms, generally via professional networks and regular checks of websites to access the 'grey' literature (policies, unpublished studies etc.)

124. **Exhibit BB** to this affidavit is an indexed copy of relevant literature and material, from both Australian and International sources, which I have reviewed in relation to transitional mental health care of adolescents.

All the facts sworn to in this affidavit are true to my knowledge and belief except as stated otherwise.

Sworn by Beth Kotzé on 18th December 2015 at Gladesville in the presence of:)

~~A Justice of the Peace, C.Dec., Solicitor~~

As a witness, I certify the following matters concerning the person who made this affidavit (the deponent):

1. I saw the face of the deponent
2. I have confirmed the deponent's identity using the following identification document: NSW Driver licence

Daniel Reserovic
Solicitor

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

Commissions of Inquiry Order (No.4) 2015

Barrett Adolescent Centre Commission of Inquiry

CERTIFICATE OF EXHIBIT

Exhibits A - BB to the Affidavit of Beth Kotzé sworn on 18th December 2015.

[redacted] .....

Deponent

[redacted] .....

~~A J.P., C.Dec.~~, Solicitor

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

Commissions of Inquiry Order (No.4) 2015

Barrett Adolescent Centre Commission of Inquiry

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BACCOI Exhibit 71, Affidavit of Beth Kotzé, 18 December 2015

Documents exhibited to this affidavit are too large to publish online.
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