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

Commissions of Inquiry Order (No.4) 2015

Barrett Adolescent Centre Commission of Inquiry

AFFIDAVIT

Margaret Ellen Jean Nightingale of Barrett Adolescent Centre, teacher, solemnly and sincerely affirms and declares:

1. I have been provided with a Requirement to Give Further Information in a Supplementary Written Statement dated 18 January 2016. **Exhibit A** to this affidavit is a copy of this notice.

2. In my affidavit, when I refer to I am referring to

3. In my affidavit, when I refer to I am referring to

4. In my affidavit, when I refer to I am referring to

The teaching program at the Barrett Adolescent Centre ('*BAC*') Special School

5. Q1(a) – The current teaching program at the BAC school is tailored to the student's individual learning needs and educational goals. When the BAC school was located at Wacol, the school was in control of setting the curriculum and teaching program for each of the students. Now that curriculum is provided by the students' base schools at which they are enrolled. While those programs are tailored to the students' individual learning needs and educational goals, I believe it is to a lesser degree than it was

Deponent A J.P.(Q).Dec., Solicitor

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On behalf of the State of Queensland

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Document No: 6317034

previously due to the logistics of coordinating between two campuses, with the base school often having very little knowledge of the student.

6. In addition to the teaching programs set by the base school, the BAC school augments the teaching program with its own program to ensure that the overall teaching program caters to the students' individual learning needs and educational goals.

7. Q1(b) – The change to the teaching program occurred gradually over time after the school moved to Yeronga. When we first moved to Yeronga, there was little guidance from the Department of Education and Training. However, I believe that a change began following [redacted] This led to more interest being shown in the school by the regional office.

8. When the school was at Wacol, it was not necessary for the students to be enrolled with other schools because their complete enrolment was with the BAC school. Over time this changed, so that now the students are required to be enrolled with another school as their base school. Another difference between the schools at Wacol and Yeronga is that when we first got to Yeronga, the school did not have the same space or resources that it had at Wacol. There was also a change in how the day would run, particularly as at Wacol the students would have times of the day, such as lunch time, where they were supervised by the health staff.

9. The changes made the students feel uncomfortable. Their discomfort was related to their new location, and logistical changes, rather than the change in the teaching program itself.

10. The changes in location impacted on the ability of some of the students to attend. This is because of a number of factors including:

(a) travel issues;

(b) anxiety; and

(c) a lack of sense of belonging at the new location.

11. The new teaching location necessitated a change to the teaching programs in terms of outings. At Wacol, the school day would commence with a morning walk through the grounds. This was more difficult, and not as ideal at the new location.

12. There was also a need to change the teaching program in terms of community connections with sporting areas and the activities that were undertaken as part of the process of community re-integration.

13. At the new location at Yeronga, it was also more difficult to focus on the teaching program if students became unwell. This was because of the absence of health staff to supervise students.

14. While the students felt gratitude towards the school still being in existence, and for the continuity of teaching staff, they were otherwise distressed by the changes.

15. Q1(c) – At Yeronga, the school continued to have three learning spaces or classrooms available. It was not until the school moved to Tennyson that this changed to having only one learning space or classroom.

16. While there was still three classrooms at Yeronga, the school did not have sufficient space for us to unpack all of our resources. This impacted on the students in that it made it difficult for them to feel settled. The students were also impacted by the reduction in break or recreational space. They had to use a small room that was also used as a small library and office space.

17. Q1(d) – The BAC school teaching program, whether based at Wacol, Yeronga or Tennyson, was based on the Australian Curriculum.

18. Q2 – The teaching program is set by a base curriculum which is then augmented with our program to focus on building the students' capacity to re-engage with their learning and their community. It achieves similar education goals to those achieved at the BAC school prior to January 2014. However, the ability to follow that teaching program is limited in the way described above with respect to a reduction in resources and space, as well as the limitations experienced due to an absence of mental health support staff.

Working hours

19. Q3 – Originally, the Department of Education and Training told the education staff that only the permanent staff would have jobs. I do not have a clear recollection of when we were told this, but I think it may have been told to us by Peter Blatch around November 2013. At that time, I was on a contract.

20. Once we moved to Yeronga, I was able to come in on a casual basis. Initially though, I did not know what changes would happen to the budget for the school and I was not aware of what teacher aide allocation would be given to the school. As I was in a contract position, I was told that it was likely that my contract would not be renewed but that there may be some availability for me to do some casual shifts. I believe that once there was a greater understanding about how the location change affected the school budget, funds were available for me to work some shifts as a teacher aide.

Communications

21. Q4 – In paragraph 52 of my original statement, what I meant by '*middle management meetings*' is meetings at the regional level of the Department of Education and Training, such as meetings involving the Assistant Regional Director or Regional Director

22. Q5(a), (b) and (c) – In relation to the wish list of services mentioned in my email to Greg Fowler attached as Exhibit G to my original statement:

(a) there have been no mental health staff provided on site to support the students, despite numerous requests;

(b) wireless internet connection has only recently been provided; but this is limited to the office area only. We are still unable to use the school server for students to access the internet in the learning spaces.

(c) the school has been able to borrow a vehicle from the education fleet – it has not been a six seater vehicle, but we have had use of two vehicles;

(d) there has been no access to either a visiting or full time occupational therapist, or even a school nurse; and

(e) the school has been operating as a stand-alone school with its own budget.

23. Q6 – With respect to paragraph 55 of my original statement, the conversations with Annastacia Palaszczuk occurred when she visited the Forest Lake State School for a school event. I was the P&C president at Forest Lake and knew Annastacia reasonably well as she often attended school events. I cannot recall the date of that meeting, but do recall that I mentioned to Annastacia that I had concerns about the closure of the Barrett Adolescent Centre ('*BAC*'). I got the impression from Annastacia that other people had expressed similar concerns to her. At some time after that meeting, Annastacia Palaszczuk and Lawrence Springborg visited the BAC on 11 December 2012. On their visit, they were shown around the facility and met with Kevin Rodgers and some of the other senior health and education staff. They also met with students. On that occasion, I had an opportunity to briefly chat with Mr Springborg. Annastacia Palaszczuk was standing with Mr Springborg when I directed my concerns

to him. My concerns were that there was insufficient treatment options for students if the BAC was to close.

24. On that same visit, I observed Mr Springborg speaking with the students. Later, the students and other staff reported the content of those discussions to me. [redacted],

[redacted]

25. I am also aware that on that visit, Mr Springborg was photographed with the students, [redacted]

Employment at the BAC

26. Q7(a) – I had significant involvement in the transition of patients from the BAC into alternative services during my employment as a Clinical Liaison Person and Acting Clinical Nurse between 1998 and 2000. My involvement included liaising with the services that the patients would be transitioned to, including both residential and therapeutic services. It was often difficult to find places for the patients, particularly if the patients were not going back home.

27. I was also involved in decisions about the time frame over which the patients would be transitioned, conditions on which the patients could return to the BAC and whether the transition might involve dropping a patient back from being an inpatient to a day patient.

28. In those transition arrangements, the staff always tried to allow a period of time of continued support so that, should a patient become unwell and need increased care, they could come back to the BAC as a day patient or for a respite stay.

29. Q7(b) – There was a big difference between the transition of patients and students following the closure of the BAC in January 2014 compared to the '*business as usual*' transactions that I encountered during my employment as a Clinical Liaison Person

[redacted] [redacted]

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

Document No: 6317034 [redacted]

and Acting Clinical Nurse between 1998 and 2000. The ability to have ongoing involvement was fast tracked, if it was present at all. There was no option of return to the BAC and contact with the patients diminished fairly quickly. Also, previously there were numerous visits to the residential care option to which the patient was being transitioned prior to their eventual move into that service. That allowed the patient to meet the people at the service, attend some of the activities with other residents at the service and gradually increase their exposure to that new environment.

30. This allowed the patients to build a sense of belonging and attachment to the new option. It also allowed the patient to come back after each visit and talk through the visit to deal with their anxiety. Subsequent visits could then be for an extended period.

31. In the transition of patients between 1998 and 2000, there was also more involvement with schooling and vocational options. The school would have longer to process the transition of the students to other schools or jobs or types of training.

Key challenges

32. Q8 – I could not really say what informed the decisions of the nursing staff. However, I have an impression that from late 2012 there was increase in staff changes because there was no clarity about what was happening with the BAC. Following the removal of Dr Sadler, the staff changes were amplified. The staff appeared concerned about the uncertainty around their job security and changes to the working conditions. It was also reported to me by nursing staff that there was increased scrutiny of their professional behaviour in relation to not discussing the closure of the BAC.

33. Q9 – I formed my impression that the nursing staff felt bullied and intimidated from my observations of the nursing staff and from general conversations that I had with them. A number of the nursing staff had mentioned to me that during interviews with them about they felt fiercely intimidated

and that they were kept in the meeting for hours in tears. They also mentioned to me that they were being threatened with Code of Conduct breaches. Some nurses were led to believe that email and phone records would be checked. I cannot recall which nurses I discussed these matters with. There were general comments of this nature being made by a number of the nursing staff over time.

34. The reluctance of nurses to discuss matters with teaching staff was, I believe, because of the fear of being reprimanded for breaching the Code of Conduct.

35. I do not know who was involved in the interviews of the nursing staff with respect to the incident, nor do I recall the nursing staff ever specifically mentioning who was making the threats. I do have an impression, however, that the message filtered down from Sharon Kelly and Lesley Dwyer. My impression in that respect was reinforced on the two occasions when I was in meetings with Sharon Kelly and Lesley Dwyer. One of them (I cannot recall which) was particularly stern in her approach in those meetings. For example, in the first meeting that was held following the leak by the media of the potential closure in November 2012, Sharon Kelly and Lesley Dwyer were attempting damage control. They said that there had been no decision to close the BAC. I probed them on the issue to obtain clarification. At that meeting, I witnessed very intimidating behaviour by Sharon Kelly or Lesley Dwyer (I cannot recall which) when the staff asked a question. Effectively, the staff member would be shut down.

36. On those occasions, having seen the health staff shut down, I sought to probe further on the issue. I recall querying how they could say that there had been no decision to close when they were also saying that the BAC could no longer remain in the current buildings and that there was no funding to build a new location nor was there any other alternative location. I recall asking how you can have such a service if there is no

location for it. The response was along the lines '*no final decisions have been made about closure of the centre*'.

37. I recall that after the meetings I got thanked by several health and education staff for speaking up.

38. There was a second meeting where that type of dialogue occurred. The other meeting also involved discussions about the types of services that would be available and where the patients would go.

39. I recall expressing concerns that none of the patients could have their needs met by existing services so how would they be looked after if the BAC was to close.

40. This second meeting was some time later than the first meeting. It was the last meeting that the education staff were invited to by West Moreton Hospital and Health Service.

41 I also recall that, at those meetings, the overwhelming theme, in terms of the comments and queries by the staff, was a concern for the patients, not just for their own jobs.

42. Q10 – I recall that the education staff began to feel isolated after the media coverage associated with the current affairs television show '*The Project*'. Around that time there were views that education staff were being obstructionist. It was around that time that the nursing staff stopped talking to the education staff. This is what led to the sense of isolation. The sense of isolation was heightened because we were not in receipt of any of the newsletters that were being provided to the health staff, nor were we invited to any of the meetings held by health.

43. Q11 – The removal of Dr Trevor Sadler was a key challenge in my role at the BAC school because it was from that time that the multidisciplinary team seemed to fragment. After his removal, the staff at the school did not feel they had as much

involvement in what was happening. There were also a lot of rumours occurring at the time.

44. In addition, interactions with students were more challenging as the students felt unsafe. The students had relied on Dr Sadler and I believe some had felt a sense of abandonment. The students were also unsettled by the need to interact with a new doctor, and were distrustful of the new doctor. This made it more difficult to engage with the students, which in turn was distressing me and other education staff.

45. The removal of Dr Sadler was also particularly hard for me as I had worked closely with him for many years.

46. In addition, Dr Sadler's removal resulted in a sense of injustice being felt by many of the staff. There was a general feeling that if they can remove Dr Sadler, what will they do with us. There seemed to be a fear that Dr Sadler's removal was a tactic employed as part of the decision to close the BAC.

47. Q12 – It is difficult to provide details of who was involved in the conversations about the lack of options for the future of the students. I had that type of conversation with most of the allied health staff at some stage, particularly after the initial leak of the potential closure in November 2012. The discussions were about how, for the students, CYMHS had been unable to address the students' mental health needs and AMYOS was also not sufficient for them. The students had tried everything that was otherwise available and it had not helped them. We all knew how far off any new service would be in terms of being ready. There was a strong feeling of powerlessness and impending doom amongst many of the staff as we had grave concerns for the safety of the students but felt that our pleas to hear our concerns were falling on deaf ears.

48. There were also discussions regarding the severity of the illnesses of the patients and how the severity was such that other practitioners in other services would not have the experience that those at the BAC had. The practitioners at the BAC had considerable combined experience dealing with patients with severe and complex illness

49. Some of the allied health staff that I recalled having such discussions with included Georgia Watkins-Allen, Danielle Corbett, Angela Clarke, Kate Partridge and other nursing staff.

50. Q13 – '*wrap around care*' is a term used to describe the circumstance where there is availability of therapeutic care across multiple disciplines 24 hours per day. It involves consultation and liaison with families and patients.

51. Q14 – For those youth with really severe mental illnesses, who have failed in the community services programs, it is important that there is access to other services that meet their needs. Once it is established that community service programs are inadequate to meet the needs of such individuals, then the type of care and duration of care required by such patients can only be met through a higher level of services.

52. For many of the youth at the BAC, the environment was less restrictive than that which they experienced outside the centre. This is because many of them did not leave their home bedroom or have any involvement with peers or school or even people outside their family.

53. These young people would come to BAC where they would engage with others. The BAC provided community access and involvement. Once the patients became accustomed to engaging with others at BAC, they were able to be integrated into their community.

54. During the patients' time at the BAC, they regularly went home, including the increasing periods of time as their mental health improved.

55. For patients with a high risk of suicide, it was very important that they be provided a safe environment so that they would have the protection that they needed.

56. The BAC helped the patients re-engage with life and actively provided therapy. This is a very different experience to what occurred in adult wards.

57. Q15 – The community services programs that were being set up or expanded, as referred to in paragraph 61 of my original statement, were CYMHS, Headspace, AMYOS and Evolve.

58. As more services became available over time, more patients could be treated by those services, and consequently those services developed greater expertise. This meant that some patients who would previously come to the BAC, could now be managed elsewhere. The flow-on effect was that those patients who did come to the BAC were consistently more severe towards the end of the BAC, as compared to my experience between 1998 and 2000.

59. Q16(a) – It is misleading to speak about average length of stay per student because with such a small number of available spaces, a single outlier (in terms of a patient who has a long stay) can distort the average. Having said that, when I first started working at the BAC, patients often stayed only one term or around six months. By way of comparison, in 2013/2014, immediately prior to the BAC closure, it was more common for patients to stay for 12 months, and a few patients required significantly longer stays.

60. Q16(b) – The length of stay did increase over time. This is, in part, due to a correlation with the increase in the severity of the patients admitted to the BAC, but was also associated with the absence of a step-down model.

61. A number of the patients could have been transitioned out of the BAC sooner had there not been such a large gap to the next available service.

Decision to close the BAC and transition arrangements

62. Q17(a) – With respect to the meeting with Lesley Dwyer referred to in paragraph 63 of my original statement:

(a) the meeting occurred in November 2012;

(b) the meeting was attended by Sharon Kelly and Lesley Dwyer and all available BAC staff including health and education staff; and

(c) the meeting was arranged in response to the media attention following the leak by Brett McDermott of the fact that the BAC would close.

63. Q18 – Education staff were only given an opportunity to be involved in two meetings. They are the meetings referred to earlier in my statement. Education staff were not asked to provide any input during the process that considered the future of the BAC.

64. Q19 – I was told about the ECRG review by Kevin Rodgers. I was not directly told that there was no funding for a Tier 3 service, just that there was no funding for a new building.

65. I recall that Allison Earles had a document which indicated that there was no funding for a new building. **Exhibit B** to this affidavit is a copy of that document.

66. Education staff were not involved in any discussions about the recommendations by ECRG, despite requesting to be involved, other than Kevin Rodgers who was a member of the panel.

67. Q20 – The education staff asked Kevin Rodgers whether the ECRG had recommended a Tier 3 service. He was limited in what he could tell us. He simply indicated that he was sure that the report would be furnished to us. This did not happen.

68. Q21 – The meetings referred to at paragraph 69 of my original statement are the same meetings referred to earlier in this statement. I have no copies of any agendas or minutes of notes from those meetings.

69. Q22 – Education staff were in constant contact with the parents of the students as the parents would phone the school and come into the school to ask what was happening about the transition.

70. A P&C meeting was held with the parents at one stage. I cannot remember when this occurred.

71. In addition, the teachers sent weekly emails to the parents. This was part of the standard process where each teacher was responsible for a group of students and the teacher would send an email to the parents each week about the progress that was being made at the school. As part of that email, if the teachers had any information about the transitions, they would pass that information on to the parents. I was not responsible for those emails as I was a teacher aide at the time.

72. Q23 – I do not recall when Kevin Rodgers told me that the education staff were not to attend the meetings. As for the allegations that the education staff were obstructionist, this filtered down from Peter Blatch to Kevin Rodgers from discussions he had had with management of West Moreton Hospital and Health Service.

Management decisions

73. Q24 – I cannot recall when or the circumstances in which I found out that the BAC school was going to continue but in a different location (Yeronga). I recall that different ideas were tossed around and that Peter Blatch would come out to the school and talk through what he knew about those options. Sometimes Peter met with all available education staff, other times it was just with Kevin Rodgers or Debbie Rankin. On those occasions where Peter met only with Kevin Rodgers or Debbie Rankin, the information filtered down to the other education staff through them.

74. Q25 – With respect to paragraph 72 of my earlier statement, the '*stressors around the model of service*' arose because we did not know what our role was to be when the school moved to Yeronga. As our student enrolments previously came from inpatients and because there were no longer inpatients, there were therefore no more compulsory enrolments. We did not know if we would have new students, and some uncertainty over the degree to which we would have continued involvement with the existing students. None of this was clear prior to the school moving to Yeronga. All we knew was that we would have no mental health support.

Support provided

75. Q26 – With respect to paragraph 73 of my earlier statement, all available education staff attended the meeting with Peter Blatch. I am not sure how it came about. I imagine it was part of the role Peter Blatch had assumed in keeping all of us informed where he could.

76. Q27 – In relation to paragraph 73 of my earlier statement, I believe it was Debbie Rankin who continued to attend the multidisciplinary case conferences.

77. Q28 – Justine Oxenham did not explain to me why she was not allowed to discuss the transition arrangements nor who had given her this direction. I remember looking at her when she came out of such meetings and I formed the impression that she was really concerned. I did not ask her about the matter as I did not want to add to her burden.

78. Q29 – A number of the students were offered extra semesters but, because of their transition arrangements, they could not access them.

79. I recall that [redacted] had gone to [redacted] and was unable to attend the school. [redacted]

80. [redacted]

81. I believe that [redacted] would have also benefitted from further involvement in education. [redacted]

82. There are also possibly other students who may have benefitted from extra semesters, but the specifics of who are difficult to recall now. In reality, all the students would have benefitted from further peer interaction at the school.

83. Q30 – I do not recall being given a time frame for the move of the school. I recall that there were concerns about packing the school while the students were still there because the packing caused them anxiety so we would try to do packing when there

were no students around. I do, however, recall that there was pressure for the school to be packed up over the holidays and for it to move out of the building.

84. Packing was also difficult because we did not know what space we would have at the next location, so we did not know what we needed to pack for.

85. I recall that Queensland Health claimed the building back quite quickly. They locked it up and took the keys.

86. It would have been helpful if the school was able to gradually move out over time, particularly given the building then remained vacant for quite some time.

87. Q31 – I think I was told by Peter Blatch that the Yeronga school did not want the parent body to know that the BAC special school was moving to the Yeronga school. Apparently the parent body had previously expressed concerns about the commencement of a young mothers program at the Yeronga school. I was under the impression that the Yeronga school believed that if the parent body was not happy with the young mothers group, then they would not be happy with the co-location of the BAC special school.

88. This was reinforced by my experience when we arrived. There was little or no involvement between the BAC special school and the Yeronga school. We had no access to a staff room and no one came to welcome us or even talked to us. It felt like we were the '*hidden secret*' up the back.

Concerns regarding the closure of the BAC

89. Q32 – With respect to paragraph 85 of my earlier statement, I expressed my concerns about the closure to Lesley Dwyer and Sharon Kelly at the two meetings referred to earlier in this statement.

90. As for Dr Brennan, I recall expressing my concerns to her in the kitchen on one occasion. The conversation was just between Dr Brennan and me.

91. The concerns that I expressed are those mentioned earlier in this statement, namely that the only other available services were ones which had proven to be inadequate for the patients. The patients were expressing concern that those services would not be enough for them.

92. Q33 – With respect to paragraph 85 of my earlier statement, the discussions I had with people about the closure being '*too rushed*' and a '*big mistake*' are the discussions mentioned earlier in this statement. I also had similar discussions with the union, and with other education staff as part of our general day to day discussions with each other.

93. In my opinion, the optimal time frame for the closure would have involved:

(a) time to have all of the recommended alternative services up and running prior to the commencement of transition; and

(b) sufficient time to allow a gradual transition. This would be a flexible time frame. It may be six months for some patients, but even longer for others (up to 12 months). This lengthy period was particularly required considering there was no step-down facility.

94. Q34 – With respect to paragraph 87 of my statement and my discussion with Dr Anne Brennan, I recall forming the impression that Dr Brennan could not say anything. She looked very burdened and, in response to my concerns, she acknowledged that her task was very difficult and that there were constraints. I could see that the burden weighed heavily on Dr Brennan. I got the impression that Dr Brennan did not have as much flexibility and independence in the process as she would have liked.

95. Q35 – With respect to paragraph 89, and the question framed in paragraph 35 of the notice attached at **Exhibit A**, it is important that I clarify that my position is not that I, and other education staff, '*believed that the considerations in the ECRG report nullified the recommendations*'. I never received a copy of the ECRG report, but was able to access it online recently. In paragraph 89 of my earlier statement, I am referring to a document that is **Exhibit B** to this affidavit. It was not the ECRG report. In the attached report, while some of the recommendations of the ECRG report were accepted, they were accepted with qualifications that reduced the effectiveness of the recommendations.

96. Q36 – I believe Kevin Rodgers told me that the ECRG report was finished in May 2013. I understand that the ECRG report was released some time in July 2013. While I knew there was a delay between the ECRG report being finalised and it being released, I did not know why. However, I surmise that the delay was because the report was not what West Moreton Hospital and Health Service expected to get. I believe that the ECRG report was not what West Moreton Hospital and Health Service wanted to receive. I think it wanted to close the BAC and that the ECRG report did not align with their plan so West Moreton Hospital and Health Service needed time to work out a strategy to close the BAC despite the contents of the ECRG report.

Other information relevant to the Terms of Reference

97. It seems to me that there is a perception that the BAC was not operating a contemporary model. I disagree.

98. The BAC (particularly Dr Trevor Sadler and myself) was heavily involved in developing treatment options for adolescents with complex mental health needs.

99. The BAC presented a number of conferences that had keynote speakers and other experts from multidisciplinary fields. The conferences were attended by hundreds of

delegates from schools, allied health professionals and community mental health services locally and Australia wide.

100. On occasion, keynote speakers from those conferences also came to the BAC to contribute to the ongoing professional development of the staff at the BAC.

101. The whole time I was involved with the BAC, it facilitated discussions about what works for treating adolescents with complex mental health needs and what does not. The staff at the BAC researched the services available in the mental health arena both within Australia and internationally. This research, coupled with a strong culture of reflection, informed changes which ensured the provision of a contemporary service.

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

Affirmed by Margaret Ellen Jean Nightingale)
on 25 January 2016 in)
the presence of:)

[redacted]

A Justice of the Peace, 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

CERTIFICATE OF EXHIBIT

Exhibit A to B of the Affidavit of Margaret Ellen Jean Nightingale sworn on 25 January 2016.

[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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BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

Commissions of Inquiry Act 1950
Section 5(1)(d)

REQUIREMENT TO GIVE FURTHER INFORMATION IN A SUPPLEMENTARY WRITTEN STATEMENT

To: Margaret Nightingale

Of: c/- Crown Law, by email to:

I, the Honourable MARGARET WILSON QC, Commissioner, appointed pursuant to *Commissions of Inquiry Order (No. 4) 2015* to inquire into certain matters pertaining to the Barrett Adolescent Centre ("the Commission") require you to give a supplementary written statement to the Commission pursuant to section 5(1)(d) of the *Commissions of Inquiry Act 1950* in regard to your knowledge of the matters set out in the Schedule annexed hereto.

YOU MUST COMPLY WITH THIS REQUIREMENT BY:

Giving a supplementary written statement prepared either in affidavit form or verified as a statutory declaration under the *Oaths Act 1867* to the Commission on or before **4:00pm, Monday 25 January 2016** by delivering it to the Commission at Level 10, 179 North Quay, Brisbane.

A copy of the supplementary written statement must also be provided electronically either by: email at (in the subject line please include "Requirement for Written Statement"); or via the Commission's website at www.barrettinquiry.qld.gov.au (confidential information should be provided via the Commission's secure website).

If you believe that you have a reasonable excuse for not complying with this notice, for the purposes of section 5(2)(b) of the *Commissions of Inquiry Act 1950* you will need to provide evidence to the Commission in that regard by the due date specified above.

DATED this 18th day of January 2016

The Hon Margaret Wilson QC
Commissioner
Barrett Adolescent Centre Commission of Inquiry

SCHEDULE

The teaching program at the Barrett Adolescent Centre ("the BAC") Special School

1. The Commission understands from paragraphs 32-36 of your statement affirmed on 24 November 2015 ("**your statement**"), that the teaching program at the BAC School changed after the BAC closed in January 2014. In your opinion:

   (a) Is the current teaching program at the BAC School tailored to the student's individual learning needs and educational goals?

   (b) What impact, if any, did the change in teaching program have on the students who transitioned from the BAC School after the BAC closed in January 2014? In particular, what impact, if any, did the following have on the students who transitioned from the BAC School after the BAC closed in January 2014:

   (c) The change from having three learning spaces or classrooms to only have one learning space or classroom?

   (d) The change from a teaching program based on the Australian curriculum to a teaching program set by substantive schools (the base curriculum)?

2. With reference to paragraph 35 of your statement, in your opinion, does augmenting the base curriculum with a *"focus on building the student's capacity to re-engage with their learning and their community"* achieve similar education goals to those achieved through the Australian curriculum which was taught at the BAC School prior to January 2014?

Working hours

3. The Commission understands from paragraph 49 of your statement that when the BAC closed in January 2014, there was uncertainty about whether you would be offered any shifts as a Teacher Aide. You also state in paragraph 49 of your statement that you were able to keep your shifts when the BAC School relocated to Yeronga and then to Tennyson. Please elaborate on the uncertainty regarding your shifts and on what basis

you were eventually able to keep the shifts. Please also provide copies of any documents or correspondence relating to this uncertainty.

Communications

4. Explain what is meant by "*middle management meetings*" as referred to in paragraph 52 of your statement.

5. The Commission understands from paragraph 54 of, and exhibit G to, your statement that on 20 February 2015, you emailed Greg Fowler a wish list of the services and amenities that staff believed would make delivery of the program easier. In relation to this, please answer the following questions:

   (a) Have any of the services and amenities you requested in your email of 20 February 2015 now been provided?

   (b) Please elaborate and provide details in relation to the progress, if any, which has been made in relation to the requests.

   (c) In particular, has the existing space at the BAC School been used to co-locate mental health staff to support students through the provision of a day patient/outpatient type program? What progress, if any, has been made in relation to this request?

6. To the best of your recollection, please provide further details in relation to the meeting with Annastacia Palaszczuk and Lawrence Springborg referred to in paragraph 55 of your statement.

Employment at the BAC

7. The Commission understands from paragraphs 6 and 41 of your statement that you were employed as a Clinical Liaison Person and Acting Clinical Nurse at the BAC between 1998 and 2000 and that during this time, you were involved in family therapy, individual therapy and case coordination for students at the BAC School. Please answer the following questions:

(a) To what extent were you involved in the transition of patients from the BAC into alternative services during your employment as a Clinical Liaison Person and Acting Clinical Nurse between 1998 and 2000? Please provide details of your involvement, if any, in patient transitions.

(b) To the extent that you were involved in patient transitions, how, in your opinion, did the transition of patients and students following the closure of the BAC in January 2014, differ from the "business as usual" transitions which you encountered during your employment as a Clinical Liaison Person and Acting Clinical Nurse between 1998 and 2000?

Key challenges

8. The Commission understands from paragraph 59(a) of your statement that "*from late 2012, the nursing cohort underwent increasing staff changes and quite often new nurses would not know the system*". What, to your knowledge, was the cause of the increasing staff changes that occurred at the BAC from late 2012? Was there a specific event or event/s that occurred in late 2012 that triggered these changes?

9. The Commission understands from paragraph 59(b) of your statement that education staff "*were more assertive in asking Health department representatives questions about the future of the BAC, whereas the nursing staff felt bullied and intimidated and like they could not do anything*". Why to your knowledge, were the nursing staff bullied and intimidated and by whom? Please provide examples, if possible, of when the teaching the staff were more assertive in asking representatives from the Department of Health questions about the future of the BAC.

10. The Commission understands from paragraph 59(b) of your statement that from late 2012, "*the education staff were isolated*" and were eventually "*no longer welcome in the discussions about the closure*". When did education staff first feel that they were no longer welcome in discussions about the closure of the BAC? Was there was specific event or event/s which triggered these feelings?

11. In paragraph 59(c) of your statement, you describe the removal of Dr Trevor Sadler as a key challenge in your role at the BAC School. Please explain how and why the removal of Dr Trevor Sadler was a key challenge in your role at the BAC School.

12. The Commission understands from paragraph 59(d) of your statement that *"there were lots of conversations about where was the future for these students as there was nowhere for them to go."* Please provide examples of the conversations which took place, including details of who was involved in the conversations.

13. Please explain what is meant by *"wrap around care"* as referred to in paragraph 60 of your statement.

14. In paragraph 60 of your statement, you state that *"the students who came to the BAC had already received community and/or acute hospital based care prior to their admission and continued, despite this level of service involvement, to further deteriorate. By the time they came to the BAC, their illnesses were chronic and severe"*. In paragraph 61 of your statement, you also state that *"only those with really severe mental illnesses, who had failed in the community services programs, would come to the BAC"*. The Commission understands from exhibit H to your statement that one of the reasons given in support of the closure of the BAC was that young people should be *"treated closer to their homes in the least restrictive environment, and with minimum possible disruption to their families, educational, social and community networks"*. In your opinion, is it more appropriate to treat the students described in paragraphs 60 and 61 of your statement (see above) in the community in the least restrictive environment?

15. What are the *"community service programs that were being set up"* as referred to in paragraph 61 of your statement? Please provide examples where possible. When were these community service programs being set up?

16. The Commission understands from paragraph 61 of your statement that *"the length of stay per student increased"* over your time at the BAC prior to closure. Please answer the following questions:

(a) Based on your observations and opinion, what was the average length of stay per student when you first started working at the BAC and in 2013/2014, immediately prior to the BAC closure?

(b) How did the setting up of community service programs actually increase the length of stay per student at the BAC? Please elaborate on the link between the community service programs being set up and the increased length of stay per student at the BAC.

Decision to close the BAC and transition arrangements

17. In relation to the meeting with Lesley Dwyer referred to in paragraph 63 of your statement, please provide the following details to the best of your knowledge and recollection:

(a) On what date did the meeting occur?

(b) Who attended the meeting?

(c) How did the meeting come about?

18. The Commission understands from paragraph 64 of, and exhibit H to, your statement, that you received an email from Sharon Kelly on 9 November 2012 regarding media reports about the future of the BAC. This email states that "*meetings will now be arranged with the System Manager, other Hospital and Health Services and key experts to discuss options. Staff will have the opportunity to be involved and we welcome input during this process*". To what extent were education staff given an opportunity to be involved in the meetings referred to in Sharon Kelly's email dated 9 November 2012 and provide input during the process that considered the future of the BAC?

19. The Commission understands from paragraph 68 of your statement that you "*and the other staff, were told the Expert Clinical Reference Group ("**ECRG**") had reviewed the BAC program and structure*" and that "*there was no funding for (a Tier 3 service)*". When and by whom, were you and the other staff told that the ECRG had reviewed the BAC

program and structure? When and by whom, were you and the other staff told that there were was no funding for a Tier 3 service?

20. The Commission understands from paragraph 68 of your statement that *"the education staff asked if the ECRG had recommended a Tier 3 service"*. When and whom did the education staff ask if the ECRG had recommended a Tier 3 service?

21. When did the meetings requested by Lesley Dwyer and Sharon Kelly referred to in paragraph 69 of your statement occur? What happened at these meetings? Please provide copies of any documents, agendas, minutes of notes from those meetings.

22. The Commission understands from paragraph 69 of your statement that education staff were *"in constant contact with the parents about the transition"*. Please elaborate on the details of the contact which education staff had with parents in relation to the transition.

23. The Commission understands from paragraph 69 of your statement that Kevin Rodgers told you that *"education staff were not to attend the meetings"* because you were considered obstructionist. On what date did Kevin Rodgers tell you this? To the best of your recollection, who was alleging that the education staff were obstructionist?

Management decisions

24. The Commission understands from paragraph 72 of your statement that *"for a long time after the media release in November 2012, the education staff did not know if the school was going to continue"*. When and in what circumstances, did you find out that the BAC School was going to continue but in a different location (Yeronga)?

25. What is meant by *"stressors around the model of service"* referred to in paragraph 72 of your statement?

Support provided

26. The Commission understands from paragraph 73 of your statement that there was a *"meeting with Peter Blatch who informed staff that permanent employees would still have jobs but there was uncertainty about casual and contract staff positions"*. Who attended this meeting and how did it come about?

27. Please identify the one teacher who continued to attend the multidisciplinary case conferences, as referred to in paragraph 73 of your statement.

28. The Commission understands from paragraph 73 of your statement that Justine Oxenham told you that she was *"not allowed to discuss details of the transition arrangements"*. Did Justine Oxenham explain why she was not allowed to discuss the transition arrangements and who had given her this direction?

29. The Commission understands from paragraph 74 of your statement that *"some of the students were no longer required to go to school (because of their age) but were eligible for extra semesters of schooling"*. You state in paragraph 74 of your statement that you *"believe some of the students would have benefited from those extra semesters, but they were being transitioned out into the community"*. Please identify which students you believe may have benefited from those extra semesters and explain why they may have benefited.

30. The Commission understands from paragraphs 75 and 76 of your statement that the *"move was very rushed"* and that you had to *"pack up and move over the holidays"*. Please outline any timeframe that was given to you and, to your knowledge, the other staff, for the move. In particular, when were you first told that the BAC School would be moving and how long were you given to pack up and move campuses?

31. Why did it feel *"like the Yeronga School did not want the parent body to know that the BAC special school was moving there"* as outlined in paragraph 76 of your statement? Provide examples, where possible.

Concerns regarding the closure of the BAC

32. The Commission understands from paragraph 85 of your statement that you discussed your concerns about the closure with Lesley Dwyer, Sharon Kelly and Dr Anne Brennan and that other education staff also expressed their concerns that there was an *"insufficient level of service available to support the needs of the students"*. To the best of your recollection, when and under what circumstances did these discussions occur? To your knowledge, why did education staff believe that the level of service was insufficient?

33. The Commission understands from paragraph 85 of your statement that you had a number of discussions with various people regarding the closure being *"too rushed"* and a *"big mistake"*. Please provide further details in relation to these discussions including when they took place and how they came about. Given your statement that the closure was *"too rushed"*, in your opinion, what would have been an optimal timeframe for the closure, and the adequate and appropriate transition of students?

34. The Commission understands from paragraph 87 of your statement that you had a discussion with Dr Anne Brennan about your concerns regarding the closure of the BAC and the difficulties of her task. To the best of your recollection, did Dr Anne Brennan share your concerns about the closure of the BAC or acknowledge the difficulties of her task?

35. Please explain why you and, to your knowledge, other education staff believed that the considerations in the ECRG report nullified the recommendations as referred to in paragraph 89 of your statement. Provide examples, where possible. Did you and, to your knowledge, other education staff have any other concerns with the ECRG report? If so, please provide details.

36. To the best of your recollection, on what date did Kevin Rodgers tell you and other education staff that the ECRG report was finished? On what date was the ECRG report released? To your knowledge, why was there a delay between the ECRG report being finalised and it being released?

37. Explain any other information or knowledge (and the source of that knowledge) that you have relevant to the Commission's Terms of Reference.

38. Identify and exhibit all documents in your custody or control that are referred to in your witness statement.

West Moreton Hospital and Health Service

Expert Clinical Reference Group Recommendations

Barrett Adolescent Strategy

July 2013

Queensland Government

Adolescent Extended Treatment and Rehabilitation Services (AETRS) Recommendations Submitted to the West Moreton Hospital and Health Board

1. Broader consultation and formal planning processes are essential in guiding the next steps required for service development, acknowledging that services need to align with the National Mental Health Service Planning Framework

ECRG Recommendations	Planning Group Recommendations
a) Further work will be required at a statewide level to translate these concepts into a model of service and to develop implementation and funding plans.	**Accept with the following considerations.** The responsibility for this task at a statewide level sits with the Mental Health Alcohol and Other Drugs Branch and the Children's Health Services. A collaborative partnership is proposed.
b) Formal planning including consultation with stakeholder groups will be required.	**Accept with the following considerations.** This body of work should be incorporated into the statewide planning and implementation process (as above).

2. Inpatient extended treatment and rehabilitation care (Tier 3) is an essential service component

ECRG Recommendation	Planning Group Recommendation
a) A Tier 3 service should be prioritised to provide extended treatment and rehabilitation for adolescents with severe and persistent mental illness.	**Accept with the following considerations.** Further work is needed to detail the service model for a Tier 3. Models involving a statewide, clinical bed-based service (such as the Barrett Adolescent Centre) are not considered contemporary within the National Mental Health Service Planning Framework *(in draft)*. However, there are alternative bed-based models involving clinical and non-clinical service components (e.g., Y-PARC in Victoria) that can be developed in

ECRG Recommendation	Planning Group Recommendation
	Queensland to meet the requirement of this recommendation. Contestability reforms in Queensland may allow for this service component to be provider agnostic.

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

ECRG Recommendations	Planning Group Recommendations
a) Safe, high quality service provision for adolescents requiring extended treatment and rehabilitation requires a Tier 3 service alternative to be available in a timely manner if BAC is closed.	**Accept.**
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.	**Accept with the following considerations.** While this may be a complex process for some consumers and their individual needs, it was noted that this course of action could start immediately, and that it was feasible. The potential to utilise current BAC operational funds (temporarily) to 'wrap-around' each consumer's return to their local community was noted as a significant benefit. The relevant local community should play a lead role in the discharge of the consumer from BAC and their return to home. The local services need to be consulted around their ability to provide 'wrap-around' care.
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.	**Accept.** The ECRG and the Planning Group strongly supported this recommendation.

4. Duration of treatment

ECRG Recommendation	Planning Group Recommendation
a) 'Up to 12 months' has been identified by the ECRG as a reasonable duration of treatment, but it was noted that this depends on the availability of effective step-down services and a suitable community residence for the young person. It is important to note that like all mental health service provision, there will be a range in the duration of admission.	**Accept with the following considerations.** This issue requires further deliberation within the statewide planning process. The duration of treatment needs some parameters to be set, however, this is primarily a clinical issue that is considered on a case-by-case basis by the treating team and the consumer.

5. Education resource essential: on-site school for Tiers 2 and 3

ECRG Recommendations	Planning Group Recommendations
a) Access to on-site schooling (including suitably qualified educators), is considered essential for Tiers 2 (day programs) and 3. It is the position of the ECRG that a Band 7 Specific Purpose School (provided by Department of Education, Training and Employment) is required for a Tier 3 service.	**Accept with the following considerations.** The Planning Group recommends removing *"Band 7"* from the ECRG recommendation. All educational services need to be evaluated by Department of Education, Training and Employment (DETE) on a case-by-case basis, taking into consideration service model, location, student numbers and complexity. The Planning Group supports the statement that educational resources are essential to adolescent extended treatment and rehabilitation services. The Planning Group recommends consultation with DETE once a statewide model is finalised.

ECRG Recommendations	Planning Group Recommendations
b) As an aside, consideration should also be given to the establishment of a multi-site, statewide education service for children/adolescents in acute units (hub and spoke model).	**Accept with the following consideration.** The Planning Group recommends this statement should be changed to read as: Strong consideration should be given to the establishment of a multi-site, statewide education service for children/adolescents in acute units (hub and spoke model).

6. Residential Service: Important for governance to be with CYMHS; capacity and capability requires further consideration

ECRG Recommendations	Planning Group Recommendations
a) It is considered vital that further consultation and planning is conducted on the best service model for adolescent non-government/private residential and therapeutic services in community mental health. A pilot site is essential.	**Accept with the following consideration.** Note that this service could be provider agnostic.
b) Governance should remain with the local CYMHS or treating mental health team.	**Accept.**
c) It is essential that residential services are staffed adequately and that they have clear service and consumer outcome targets.	**Accept.**

7. Equitable access to AETRS for all adolescents and families is high priority; need to enhance service provision in North Queensland (and regional areas)

ECRG Recommendations	Planning Group Recommendations
a) Local service provision to North Queensland should be addressed immediately by ensuring a full range of CYMHS services are available in Townsville, including a residential community-based service.	**Accept.**
b) If a decision is made to close BAC, this should not be finalised before the range of service options in Townsville are opened and available to consumers and their families/carers.	**Accept.**

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