

iPad Note 26/11/14

Bill Kingswell

From: William Kingswell [REDACTED]
Sent: Monday, 12 October 2015 2:29 PM
To: Bill Kingswell
Subject: Letter to Dr Sadler

iPad note 26/11/2014.

Letter to Dr Sadler

Dear Dr Sadler

As you are aware, your letter of 9 November 2014 to Mr Ian Maynard, Director General Department of Health has been provided to me in order that I might prepare a fuller response to the issues that you have raised.

As you probably also know I was involved in a number of activities associated with the closure of the Barrett Adolescent Centre (BAC). I was a member of the steering committee led by Children's Health Queensland that designed the replacement services for the BAC. That committee also received regular updates on, and oversaw the process of transitioning the young people from the Barrett Adolescent Centre into replacement options.

All the members of the steering committee were aware of the sensitive nature of the decision to close the centre and we were all aware of the significant commitment of staff (some such as yourself over many years) to managing this group of very troubled adolescents.

Was the decision wise? [REDACTED] in the months since the closure of the centre are a terrible outcome and one that all involved in this process are saddened by. Those outcomes were not intended and I do not accept that they were reasonably foreseeable. I was extremely impressed by the thorough nature of the transition planning. I am confident that we received excellent advice from well respected competent child and adolescent psychiatrists. I recall the CEO of CHQ, Dr Peter Steer commented that it was the most comprehensive transition planning he had seen for any patient group, mentally ill or otherwise. Robust treatment plans were in place for all the young people transitioned from the centre. Regrettably the [REDACTED] in spite of those plans as had a significant number of previous clients of the Barrett Adolescent Centre. You might not be aware that [REDACTED]

That number is from a cohort of only xxxx. A significant [REDACTED]

In my view the decision to close the centre was carefully considered and weighed the risks and benefits of closure versus the status quo. In that sense it was "wise". I am sure you are at least in part aware of the significant concerns raised by a number of reviews and organisations and over a period of many years. Professor McDermott led a review in 2003, another was conducted in 2009, the Australian Council of Health Care Accreditation issued a corrective action notice in xxxxx, the official visitors programme had identified concerns about patient safety and the deteriorating infrastructure in xxxxx. The reviews were universally critical. What is missing from the documentation available to me is robust evidence that any of these reviews led to meaningful change and regrettably appear to have been met with a defensive and dismissive stance rather than embracing opportunity to reflect, plan, change models of service and evaluate outcomes.

The urgency to close the centre arose when it became evident that there were very significant failures of institutional governance. [REDACTED]

The centre was identified for closure in the 2007-2017 Queensland Plan for Mental Health. Also outlined in that plan was the further development of the forensic service on that site that would result in an 'open' rehabilitation facility for adult mentally ill offenders. Leaving an adolescent centre on that site we believed was not a tenable option. The BAC itself was ageing infrastructure beyond renovation and as identified in previous reviews an unsafe facility in which to manage this group of adolescents.

Dr Bill Kingswell
Executive Director - Mental Health Alcohol and other Drugs Branch Health Service and Clinical Innovation Division
