EXHIBIT 682

FW: URGENT: Transitional Care for Adolescent Patients of the Barrett Adolescent Centre

From: Katie May-Russell
To: HSCI_Corro
Cc: Sdlo , Cathie Schnitzerling
Date: Mon, 03 Nov 2014 14:27:29 +1000
Attachments: SDLO_BAC reportja.doc (319.49 kB); ATT00001.htm (168 bytes); Talking points BAC closure report 141103.doc (32.77 kB); Min Barrett Centre report 141031.docx (20.99 kB)

Hi team

Based on the below I have pulled together the attached talking points that require approval please.

Michael already has a copy of the holding statement (attached as well) but hasn't provided any feedback on that yet.

I'll need both back by Wednesday please.

Thanks

Katie

From: news
Sent: Sunday, 2 November 2014 5:36 PM
To: Jim Guthrie; Cathie Schnitzerling; Kate Robinson; Katie May-Russell; Erin Goldsack; Andrea Grant; Theo Georga; Justine Brown; Olivia Fens; Lauren Maynard; Kirsten Roos; Belinda Berry
Subject: FW: URGENT: Transitional Care for Adolescent Patients of the Barrett Adolescent Centre

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From: Cathie Schnitzerling
Sent: Sunday, November 02, 2014 5:36:23 PM
To: news
Subject: Fwd: URGENT: Transitional Care for Adolescent Patients of the Barrett Adolescent Centre
Auto forwarded by a Rule

For Katie.

Sent from my iPhone

Begin forwarded message:

> **From:** John Allan
> **Date:** 2 November 2014 11:45:44 am AEST
> **To:** Michael Cleary Sdlo
> **Cc:** Bill Kingswell Cathie Schnitzerling Annette McMullan
> **Subject: RE: URGENT: Transitional Care for Adolescent Patients of the Barrett Adolescent Centre**
>
> Dear Michael & others

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The overall findings are positive and the message should be that

- the report says that the transition team and the clinical staff acted according to best practice in relation to the governance and the clinical planning recognising that transition of care for adolescents with serious mental health problems particularly if they have complex personal needs and problems with identity and relationships can be difficult (there is an international literature on this).
- The plans provided were appropriate and no consumer was lost to follow up and no important part of care was lost during the transition period. The investigators have provided a table – Appendix C Transition Planning Evidence Checklist documenting this.
- As in all clinical processes there were glitches and issues of miscommunication but that these were addressed by the team and had no effect on the transition process.
- The investigating team had access to all relevant written material and that all relevant staff involved were invited to participate in interviews and there was in general very good cooperation with staff members
- The one recommendation that the positive learnings in relation to good quality transitional planning inform the development of a state policy that supports mental health transition for vulnerable young people is supported and will be acted on immediately by MHAODB.

The report is reasonably favorable but there are some areas where QH is open to criticism:

- Overall it only examines one set of issues and time frame i.e. the transition and not what happened in the HHS after that
- The actions of HHSs in relation to ongoing care of these consumers was not considered and HHS apart from WMHHS had limited input into this report – there are still outstanding coroners cases to deal with these issues. There is a criticism which could be leveled that as some of the plans for consumers changed rapidly after the transition insufficient time or resources may have been given to the transition – this is not with the TOR of this report
- P4 a senior nurse from the Transition Planning Team declined to be interviewed. This was compensated for by the wealth of other material available
- P 8 “the planning was done in an atmosphere of crisis” due to the announcement of the closure standing down of a senior clinician. This created sense of time pressure despite the relatively long lead – in but probably a less than ideal amount of time considering the level of complexity for many of the consumers in terms of developing new therapeutic relationships and the need for a completely different model of care from inpatient to community. The task was enormous for the small MDT led by the Acting Clinical Director but well done in the end
- P9 issues around breakdown in communication with consumers and families as mentioned above. Seemingly overcome but the families weren’t interviewed so it is open to criticisms of balance
- P10 one example of an early termination of support – but explained by the treating team
- P11 process delays on appointing a project officer may have contributed to the sense of rush
- The change in emphasis from inpatient to community care may not be fully appreciated across the system (including reallocation of funds)

Communication with families and staff.

- Before any release the families of those consumers need to be contacted out of respect so that they do no her about it on the radio so that if they were asked to comment by the press they would be aware of the limitations and findings of this report. They need to be informed that: It is only about the governance and clinical planning of the transition and not about the ongoing clinical care. The findings of the report will be available to the coroner

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whose process is ongoing. Given the outcomes they may not agree with the investigators findings that the process was appropriate. It is not clear to me what apologies these families have had from QH It would be important for a senior QH person (DG, DDG or DMH/CP) to inform the families of the report and its findings and receive an apology for their suffering. This should be in conjunction with whoever has been their contact person in the HHS.

- The staff members who were interviewed should be informed of the content of the general report and its recommendation prior to the release. This should be done through their HHS CEO and MH Director but it may be appropriate for the DMH or Chief Psychiatrist to communicate with senior members of the former BAC given some of the clinical considerations.
- A general communication to staff as well as public about the findings should occur at the same time

If I think of anything more I'll add it tomorrow morning

Regards,

John

From: Michael Cleary
Sent: Saturday, 1 November 2014 5:18 PM
To: Sdlo
Cc: Bill Kingswell; John Allan; Cathie Schnitzerling; Annette McMullan
Subject: Re: URGENT: Transitional Care for Adolescent Patients of the Barrett Adolescent Centre

Dear Colleagues

Thank you for your assistance with this matter.

Just to confirm:
1. Cathie's team is drafting a media statement and communication package

2. Bill and John are drafting points summarising the report to attach to the Brief. You are also looking at how we might best engage with families and the relevant staff.

3. Annette is drafting a brief and letters to relevant staff. This should include advice that the report be released excluding patient information.

Kind Regards,

Michael

Dr Michael Cleary PSM
MBBS (UQ) MHA (UNSW) FACEM FRACMA AFACHSE
Chief Operations Officer
Health Service and Clinical Innovation Division
Department of Health | Queensland Government

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On 31 Oct 2014, at 15:23, "Sdlo" [redacted] wrote:

Hi John/Bill,

Please see attached the Final Report from the investigators into the Barratt Adolescent Centre.

The DG has requested urgent dot points on the report (a summary), in particular identifying any references (particularly negative references) to the two suicides.

Cathie, I believe Cam wants to go out with this on Monday so we'll need a statement organised based on the dot points that Bill/John provide. Can the dot points and statement please be circulated amongst this group, however please note the attached report should not be distributed further for the time being.

Thank you,
Jess.

Jessica Martin

Director
Departmental Liaison and Executive Support Unit
Office of the Director-General

[redacted]

<Final Report Transitional Care for Adolescent Patients of the Barrett Adolescent Centre.pdf>