IN THE MATTER OF THE BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

METRO SOUTH HOSPITAL AND HEALTH SERVICE (MSHHS)

CLOSING SUBMISSIONS

TRANSITION COMMENCEMENT

1. MSHHS, through Professor David Crompton, recognised that the transition of patients from BAC was something which involved some special care. Once the decision was made, and it was communicated to Professor Crompton, that MSHHS would be receiving some patients from BAC, his focus was on putting in place the best transition for the patients achievable. Generally, he was comfortable that MSHHS would be able to manage the consumers discharged to it and provide them with appropriate care.[1] MSHHS had clinicians with expertise in the treatment of the conditions suffered by the former BAC consumers and Professor Crompton was confident MSHHS had the capacity and resources to accept the consumers within the proposed timeframe.[2]

2. Professor Crompton met with Dr Leanne Geppert at Royal on the Park following a meeting on another issue on 29 October 2013, and he presumes it was at that time that he was informed that West Moreton Hospital and Health Services ('WMHSS') proposed to discharge consumers with complex cases to MSHHS.[3] Following that, a meeting was held on 6 November 2013 to discuss the transition of care of consumers to MSHHS.[4]

3. Although it would not normally be a part of his role to assist in the facilitation of consumer transitions to MSHHS, in this case, given that MSHHS was to receive a number of BAC consumers into its service, Professor Crompton wanted to ensure that the transition of those consumers was managed as smoothly as possible and that the care to be provided to those consumers was appropriate to their needs.[5]

4. The transition of care meeting was facilitated in order to identify the consumers to be discharged to MSHHS, their care needs and the team that would be responsible for the care

[1] MSS.900.0002.0016
[2] MSS.900.0002.0016
[3] MSS.900.0002.0018
[4] MSS.001.0002.0081
[5] MSS.900.0002.0019

of those consumers.[6] It also created an opportunity to open a dialogue with WMHSS for the transition of care of the identified consumers to MSHHS.[7]

5. The meeting was designed to be, and was in fact, a proactive approach to the transition to ensure that all the right teams were in one place and could liaise with each other concerning the consumers to be discharged to MSHSS.[8]

6. What was crucial was that each patient was treated as an individual and the transition plans for that patient involved a consideration of the particular circumstances which applied to that patient, and care and treatment was structured according to the individual requirements of that patient.[9] This is what in fact occurred in respect of the elevant patients.[10]

TRANSITION OF – para 634 et seq of Counsel Assisting's submissions

7. There are some matters within Counsel Assisting's submissions relating which call for a response:

   (a) some by way of clarification and context;

   (b) and another by way of contrary submission. (This is the matter concerning the proposition advanced in Counsel Assisting's submission that there was a deterioration in condition due to delay in funding).

8.

9. This planning commenced prior to at the BAC on At that time there was a reported verbal agreement between WMHHS and Dr Brennan that Nextt Health would be provided with the funding to provide support for It was proposed that moved

[6] MSS.900.0002.0019
[7] MSS.900.0002.0019
[8] MSS.900.0002.0019
[9] MSS.900.0002.0016
[10]
[11] MSS.002.016.0161

in order to maintain contact.[12] As part of the transition planning, attended the [13] As observed by Counsel Assisting, it was not proposed that the would only become involved after turned : they were in fact involved with the transition prior to that time.

10. As Counsel Assisting also, with respect, correctly notes,[14] due to a deterioration in mental and physical condition was transferred from the BAC to the Although there for longer than intended, was not, "kept" there for in the literal sense.[15] Rather, as Counsel Assisting also correctly identify,[16] had significant periods of leave over that period, while maintaining status awaiting appropriate accommodation and support in the community. Over that period, there were efforts by various persons to secure finance and suitable support and accommodation arrangements. In the meantime, continued to be actively involved in care. The chronological detail of these events is set out below, simply to provide to the Commission some assistance in understanding a more comprehensive chronology should that be required.

11. On admission, noted in the clinical record:

> *due to the impending closure of the BAC. Plans are in the* (sic) *the place for to be transitioned to the at the once housing is secured. The writer will attend a Stakeholders meeting tomorrow to gain clarification around plans*"[17],

and wrote:

> "*...At present, presents as future oriented, optimistic that can manage the leave to* (this had been planned at the BAC prior to *otherwise happy to be on happy that through grief/loss re: Barrett and transition to community*".[18]

[12] MSS.002.016.0161
[13] MSS.002.016.0161
[14] In paragraph 655 of their submissions
[15] That terminology is used in paragraph 656 of Counsel Assisting's submissions
[16] Paragraph 670
[17] MSH.002.004.2696
[18] MSH.002.004.2700

12. On 18 December 2013, [redacted] agreed to return to [redacted] after [redacted] leave, noting that [redacted] did not want to stay forever.[19]

13. The 'Consumer Care Review Summary and Plan' of 9 January 2014, states, "*The main purpose of the* [redacted] *is to assist* [redacted] *with transitioning to the Community and ease community follow-up when* [redacted] *is discharged from hospital.* [redacted] *is awaiting Transitional Housing in the* [redacted] *area*".[20]

14. [redacted] had planned leave to return to visit [redacted] from [redacted] It was also proposed that [redacted] have leave out of hospital on [redacted] return with [redacted] from BAC [redacted] had previously had leave to stay with [redacted] and [redacted] while at the BAC).[21]

15. [redacted]

16. [redacted]

17. [redacted] continued to have extensive independent day leave, including going to the movies, shopping, visiting friends, returning to [redacted] undertaking a period of work experience placement in a [redacted] and to attend appointments at the [redacted] leave included the use of public transport and taxi

[19] MSH.002.004.2703
[20] MSH.002.004.2725
[21] MSH.002.004.2706
[22] MSH.002.004.2677
[23] MSH.002.004.2713
[24] MSH.002.004.2713
[25] MSH.002.004.2719-20
[26] MSH.002.004.2731
[27] MSH.002.004.2736- MSH.002.004.2766

vouchers, with some leave going into the evenings. to stay with friends.[30]

18.

19. At paragraph 670 of their outline, Counsel Assisting submit that transition plans stalled due to lack of funding. This is, in a sense, true, however there were added complexities. That is, the delay in transitioning

20.

21. On 18 December 2013, at the multiagency transition of care meeting, attendees were advised funding was available for until the end of the financial year, that is, June 2014. The Mental Health Branch was to manage the funding and was required to put in a formal request to have the money disbursed.[37] The also submitted an

[28] MSH.002.004.2761
[29] MSH.002.004.2775
[30] MSH.002.004.2761
[31] MSH.002.004.2766
[32] MSS.002.004.0424
[33] MSH.002.004.0772
[34] MSH.002.004.0783
[35] MSS.004.002.0132
[36] MSS.002.016.0107
[37] MSS.004.002.0131

application to the [redacted] for funding to support [redacted] at the end of the financial year.[38]

22. [redacted] was not pursued due to its estimated provisional costings.[39] Other alternatives were explored.

23. [redacted]

24. [redacted]

25. [redacted]

26. [redacted]

27. On 17 January 2014, Laura Johnson, Project Officer – Redevelopment Mental Health & Specialised Services, requested that MSHHS submit its request for funding including the final costings for accommodation and Non-Government Organisation support to Dr William Kingswell, Dr Stephen Stathis and Dr Geppert for consideration.[49] The request for $84,495.00 was made on 30 January 2014.[50] Dr Kingswell formally approved funding in the amount of $84,495.00 on 3 February 2014.[51]

[38] MSS.100.006.7140
[39] MSS.100.006.1707
[40] MSS.004.002.0124
[41] MSS.002.016.0025
[42] MSS.002.016.0019
[43] MSS.002.016.0019
[44] MSS.002.016.0219
[45] MSS.101.001.0993
[46] MSS.003.003.0711
[47] MSS.001.003.0043
[48] MSS.100.006.6875
[49] MSS.004.006.0297
[50] MSS.900.0002.0025
[51] MSS.001.001.0060

28.

Did the delay lead to deterioration?

29. As will be apparent from the chronology above, there were various challenges in finding a suitable placement, including funding and who was to provide same: initially there was an understanding that WMHHS would provide funding, and later that understanding was displaced by an understanding that the Mental Health Branch would provide the funding.

30. In any event, submit that the evidence does not support the inference that delays in funding, leading to what is described in Counsel Assisting's submission as a "stalling of transition arrangements", led to a deterioration in condition.[55] It is submitted that on analysis of the evidence, including the clinical progress notes for [56] such an inference could not be safely drawn, and the Commission should not make any finding to that effect.

31. While it is acknowledged expressed frustration at times regarding the time it was taking to obtain accommodation, and that condition fluctuated from time to time due to anxiety about future, was, in fact, predominantly stable.

32.

33.

[52] MSS.001.003.0043
[53] MSS.001.003.0043
[54] MSS.004.002.0079
[55] See paragraph 674 of Counsel Assisting's submissions.
[56] MSH.002.004.2696- MSH.002.004.2766
[57] For examples see: MSH.002.004.2732; MSH.002.004.2736; MSH.002.004.2722; MSH.002.004.2748; MSH.002.004.2752; MSH.002.004.2765; MSH.002.004.2784

34. On full consideration of the evidence, it is submitted that the Commission would not make a finding that the delay in funding arrangements, in fact, led to a deterioration in condition. Associate Professor Beth Kotze was asked by Counsel Assisting "*whether or not that delay and having to stay in the unit for in any way impacted on the transition arrangements for* Associate Professor Kotze answered that she did not think it was a major issue, noting that although it was disruptive to a certain extent, it was not markedly so, observing that "*still had the reassurance of expert care in a ... therapeutic environment.*"[60]

35. In any event, in so far as MSHHS is concerned, the evidence is clear that MSHHS was active in seeking to find solutions to the funding and related accommodation and support issues throughout the relevant time period. MSHHS responded in a timely and reasonable manner in so far as was possible concerning these issues.

36. MSHHS does not cavil with the general proposition advanced in paragraph 677 of Counsel Assisting's submissions.

SUPPORT TO THE FAMILIES OF TRANSITION CLIENTS

37. At paragraph 708 of their submissions, Counsel Assisting submit that "*the overwhelming evidence from families is that they were not adequately informed or consulted about the closure of the BAC, transition arrangements of their children and development of new services.*"

38. In so far as MSHHS is concerned:

(a) the only topic within this submission of relevance is the transition arrangements; and

(b) the only matters in evidence relevant to that topic is the extent of the communication from the receiving team at MSHHS with

39. The evidence in respect of that topic will be set out below, however may we respectfully commence by making the submission that caution should be taken in making a generalised

[58] MSH.002.004.2806
[59] MSH.002.004.2768
[60] 23-45.34-39

finding reflective of the wording in paragraph 708 of Counsel Assisting's submissions. In that regard, it is submitted that the generalised wording might give the false impression that there was fault at the hands of a receiving agency, such as MSHHS, in respect of information / consultation with family members of the patients received by the receiving agency. The risk that a general statement such as that in paragraph 708 may create such a false impression is heightened if coupled with other submissions (which appear in the outline within the same section), that is:

(a) An unqualified reference to the complaint by [redacted] that [redacted] was not informed of certain matters, including that [redacted] had a new psychiatrist, what [redacted] medications were or what the triggers might have been that showed [redacted] was under stress (at paragraph 694 of the submissions); and

(b) An unqualified reference to [redacted] allegations that following [redacted] discharge from the BAC in late 2013, [redacted] condition deteriorated sharply (at paragraph 698 of the submission).[61]

40. That this would be a false impression is shown by:

(a) The absence of evidence to that effect in respect of the patients [redacted] and [redacted] and

(b) In respect of the evidence regarding [redacted] the evidence as to the decision making in respect of communication with [redacted] was that:

(i) [redacted] had been transitioning to independent living since September 2013;

(ii) The express wishes of [redacted] were that [redacted] not be informed in respect of matters relating to [redacted] treatment; and

(iii) Given that [redacted] was capable of giving or withholding such consent for disclosure, it was also wholly consistent with both the Psychologist's Board Code of Ethics[62] and the Australian Psychological Society Guidelines for Ms Emma White (psychologist, [redacted] not to inform [redacted] of matters related

[61] As will be submitted below, [redacted] evidence in this respect ought to be read in light of the clinical records and the evidence of the clinicians. That is, although [redacted] did suffer an acute episode which required some inpatient treatment, this was, in fact prior to the closure of BAC, [redacted] stabilised while in hospital, and then was doing well for the balance of the transition period.

[62] MSS.008.001.0017, at page 15 of that document.

to To act contrary to express wishes in that respect would not only amount to a breach of the Code of Ethics and Guidelines, it would also have been something which was of course very important in building a productive and healthy therapeutic relationship.

41. In respect of this matter, the clear evidence from Ms White was that:

(a) Ms White had formed the opinion that was able to make decisions not to divulge information to

(b) She was under no doubt whatsoever that did not want Ms White to speak with

(c) Having formed that opinion, it was obligation to respect those wishes;[66]

(d) In these early stages, that is December 2013, through to early January 2014, it was extremely important that In order for to continue engaging with the service, rapport is essential and the patient needs to trust the clinicians involved in their care;[68] That, too, was a consideration in her thought processes about whether or not to engage with it was about respecting confidentiality, it was important for rapport, and that time there were no emergent risks;[69] and

(e) She was concerned that if she had divulged information to against that would have damaged the prospect of a good rapport with

[63] MSS.008.001.0001 at page 6 – 7, parts 4.2 and 5.
[64] 22-12.38. Note also that Dr Brennan thought was competent: 9-74.11
[65] 22-13.19
[66] 22-12.42
[67] 22-12.45
[68] 22-13.3
[69] 22-13.5-10
[70] 22-13.13

WAS [redacted] A "TRANSITION PATIENT" AS THAT TERM IS USED IN THE TERMS OF REFERENCE

42. [redacted]

(a) [redacted]

(b) [redacted]

SOME ASPECTS RELATING TO [redacted] AND TRANSITION

43. [redacted]

44. [redacted]

[redacted]

45. It is submitted that the Commission would not find that [redacted] condition deteriorated sharply in the transition period. Some relevant context in this regard follows.

[71] 17-82.1-17
[72] 22-63.42
[73] 22-79.4-19

46.

47.

48. It is to be noted, generally, that in the transition arrangements:

(a) retained the services of through which was to receive structured treatment, and with whom there was a strong therapeutic alliance;[77]

(b)

(c)

(d)

49. Thus, had the support of a team of clinicians.

50.

[74] 22-11.42-47
[75] MSS.002.003.0756
[76] MSS.900.0003.0702
[77] MSH.002.003.0676

[redacted]

[redacted]

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[78] 22-12.20 – 35; MSS.002.003.0183