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

WRITTEN OUTLINE OF SUBMISSIONS ON BEHALF OF DR ANTHONY O'CONNELL

1. Dr Anthony O'Connell was the Director General of Queensland Health from June 2011 to 15 August 2013.

2. The terms of reference applicable to Dr O'Connell are 3(a), (b), (c) and (g):

   *(a) the decision to close the Barrett Adolescent Centre (BAC) announced on 6 August 2013 by the then Minister for Health, including with respect to the cessation of the onsite integrated education program (the **closure decision**);*

   (b) the bases for the closure decision;

   (c) without limiting paragraphs (a) and (b) above – the information, material, advice, processes, considerations and recommendations that related to or informed the closure decision and the decision-making process related to the closure decision.

   (d) -

   (e) -

   (f) -

   (g) any alternative for the replacement of BAC that was considered, the bases for the alternative not having been adopted, and any other alternatives that ought to have been considered;

3. The Commissioner has required that submissions be made on: who had the legal authority to close the BAC; and who purported to exercise such authority and on what occasions?

4. Issues that are pertinent to Dr O'Connell are as follows:

   (a) Who had the authority and who exercised the authority to make the decision to cease the Redlands project?

(b) What were the inputs and reasons for that decision?

(c) Was that decision confined to the government's budget strategy?

(d) What were the terms and effect of the WMHHB's decision of 24 May 2013 to close the BAC?

(e) What were the inputs and reasons for that decision?

(f) What services were available that presented alternatives to the service provided by the BAC?

WHO HAD THE LEGAL AUTHORITY TO CLOSE THE BAC?

5. Prior to 1 July 2012 section 59 of the *Health Services Act* 1991 (*HSA*) stated: "*The chief executive, subject to the Minister, has the overall responsibility for the management, administration and delivery of public sector health services in the State.*"

6. After 1 July 2012 reforms took effect pursuant to the *National Health Reform Agreement* 2011 which meant that the Department of Health, through its Chief Executive became the "system manager". Responsibility for frontline delivery of health services was devolved to the Hospital and Health Services (HHSs). The HHSs were established as separate legal entities to be governed by a governing council and chief executive officer.

7. After July 2012 the Director General worked in partnership with the HHSs and advised and made recommendations to the Minister that ensured the public health system delivered high quality health services.[1]

[1] As a result of section 8 *HHB Act* and the Service Agreement between the relevant HHS and the Department.

8. Section 8 of the *Hospital and Health Boards Act* 2011 (*HHB Act*) dealt with management of the public sector health system and stated:

> *8(2) The overall management of the public sector health system is the responsibility of the department, through the chief executive (the system manager role).*
>
> *8(4) The way in which the chief executive's responsibilities are exercised establishes the relationship between the chief executive and the Services.*
>
> *8(5) The relationship between the chief executive and the Services is also governed by the service agreement between the chief executive and each Service.*

9. The Service Agreement between the WMHHS and Queensland Health 2012-2013[2] set out the System Manager Accountabilities:

> *"Without limiting any other obligations of the system manager, it must comply with:*
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> - *the terms of the service agreement;*
> - *the legislative requirements as set out within the Hospital and Health Board Act 2011;*
> - *all regulations made under the Hospital and Health Board Act 2011; and*
> - *all cabinet decisions applicable to Queensland Health.*
>
> *The system manager will work in partnership with HHSs to ensure the public health system delivers high quality hospital and other health services to persons in Queensland having regard to the principles and objectives of the national health system. In support of realising this objective, in accordance with Section 5 of the Hospital and Health Board Act 2011 the system manager will:*
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> - *provide state-wide health system management including health system planning, coordination and standard setting, and*
> - *balance the benefits of the local and system wide approach."*

10. By s.44 of the *HHB Act* the Minister could give a HHS a written direction about a matter relevant to the performance of its functions under the *HHB Act,* if the Minister

[2] QHD.004.007.4997 at page 12.

was satisfied it was necessary to do so in the public interest and a HHS must comply with a direction given by the Minister.

11. Further, at relevant times, by s.44F the Chief Executive was, for relevant purposes, subject to the direction of the Minister in managing the Department.

12. Pursuant to the terms of the Service Agreement between WMHHS and Queensland Health, the WMHHS was required to operate the BAC.[3] The 2013/14-2015/16 Service Agreement under the heading of "*Mental Health and Alcohol and Other Drug Facilities and Services*" provided on page 27 that the WMHHS had oversight responsibility for the delivery of the Adolescent Extended Treatment and Rehabilitation Centre state-wide service.

13. The Agreement at pages 7 and 8 provides for how the Agreement could be varied. It stated that section 39 of the *HHB Act* required that if the Chief Executive or the HHS wanted to amend the terms of a service agreement, the party wishing to amend the agreement must give written notice of the proposed amendment to the other party (the Amendment Proposal) which then had to be dealt with, during set periods of time during the year known as "Amendment Windows". There was a tiered process of negotiation and resolution by which amendments were agreed and executed by way of Deed of Amendment.

14. A decision to close the BAC could only be legally affected by amending the Service Agreement, because absent that WMHHS was obliged to operate it.

[3] Service Agreement 2013/14-2015/16 LJS.002.001.0014 signed by Dr Tony O'Connell as Chief Executive of Queensland Health on 20 June 2013 and signed by Mary Corbett as Chair of the WMHHB on 28 June 2013.

WHO PURPORTED TO EXERCISE AUTHORITY TO CLOSE THE BAC AND ON WHAT OCCASIONS?

15. There was a longstanding expectation that the BAC facility would close.[4]

16. The WMHHS Mental Health Service Executive Director sought approval from the WMHHB for closure of the BAC by December 2012, evidenced by a Briefing Note dated 26 October 2012. [5] This Briefing Note however was not actioned. Deputy Director-General, Dr Michael Cleary placed a note dated 2 November 2012 over the top of the October Briefing Note which asks: "*Can we please add a signature box for the CE Ipswich and West Moreton HHS so that it is clear that the HHS is seeking this approval. I would also suggest that we clarify if the Board of the HHS has considered and approved this. We should also add a section in that indicated that subject to approval being provided that a project and communication plan will be developed and provided to the DG.*"

17. This coincided with Ms Sharon Kelly's work to have the WMHHB make the decision in November 2012.[6]

18. The WMHHB met on 24 May 2013 and considered a recommendation to progress the closure of the BAC. Sharon Kelly prepared a Board Paper entitled the "Barrett Adolescent Strategy – Recommendations" recommending the WMHHB support the closure of the BAC. The May 2013 Agenda Paper for the WMHHB meeting suggested a date of 30 September 2013 for closure. The Board however did not want to fix any particular date and wanted a more generous period to ensure a date for closure was determined by clinical need rather than a predetermined arbitrary date. The Board

[4] Supplementary affidavit of Dr O'Connell page 5 paragraph 6.
[5] QHD.004.013.9670
[6] Statement of Sharon Kelly WMS.9000.0006.00001 paragraph 10.5.

therefore did not endorse that recommendation.[7] The recommendations of the ECRG and the Planning Group were considered and the WMHHB resolved to support the closure of the BAC.[8]

19. By Briefing Note dated 8 July 2013[9] the WMHHB sought the Minister's approval of its decision to close the BAC. The July Briefing Note states that it's decision was "*dependent on alternative, appropriate care provisions for the adolescent target group and the meeting with the Minister for Health.*"

20. The July Briefing Note noted a scheduled meeting for 4pm on Monday 15 July 2013 between the Minister for Health, Dr Mary Corbett (Chair WMHHB), Lesley Dwyer (Chief Executive, WMHHS) and Sharon Kelly (Executive Director, Mental Health and Specialised Services, WMHHS) to discuss the next stages of the Barrett Adolescent Strategy.

21. The Minister then announced on 6 August 2013 that closure of the BAC would occur on a future date.

22. As noted earlier, the closure decision could only be affected by a variation to the Service Agreement between the WMHHB and Queensland Health. Up until the Service Agreement was amended, WMHHB was contractually obliged to operate the BAC. Further, the BAC was in fact continuing to operate.

23. The Terms of Reference refer to the "closure decision" as "the decision to close the BAC announced on 6 August 2013". That is a mischaracterisation. Rather, the

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[7] Statement of Sharon Kelly WMS.9000.0006.00001 paragraph 13.3.
[8] Statement of Lesley Dwyer WMS.9000.0010.00001 page 14 paragraph 8.4.
[9] QHD.008.001.3858

decision being announced then was in truth to move towards closure or to prepare for a closure.

24. The July 2013/14-2015/16 Agreement between WMHHS and Queensland Health[10] at page 12 sets out accountabilities of WMHHS including the obligation to comply with the terms of the Service Agreement and relevantly to meet all of the accountabilities regarding mental health services. This obligation gave WMHHS oversight responsibility for the state-wide service provided at the adolescent extended treatment and rehabilitation centre at The Park. The processes required to amend the Agreement are set out in the Agreement itself. The amendment document which ceased the contractual obligation of the WMHHS to operate the BAC was signed by Ian Maynard, Director-General, on behalf of Queensland Health on 6 August 2014 and by Mary Corbett as Chair of the WMHHB on 29 August 2014.[11]

25. Strictly speaking, by such a process, a decision to close the BAC could have been made by any number of officers of each WMHHS and Queensland Health as permitted by it. The Board could have caused that to happen with the assent of the Director-General, if not resolved at lower levels.

26. The Minister had made it known that a decision such as the closure of a facility was a matter that he had to be consulted about; it was a decision requiring his approval before it could be acted upon. [T15-38 lines 36-39, 42-43 and T15-39 lines 8-11 and T15-41 lines 12-13] If the Minister did not approve, it was open to him to exercise his power under s.44 to direct it to do otherwise or under s.44F if necessary or applicable. As a matter of practicality either because of that power or otherwise, West Moreton plainly appreciated it would and should only proceed if it had the Minister's approval.

[10] LJS.002.001.0014 Exh.00182
[11] LJS.002.0001.0062 Exh.00183

27. The approval of the WMHHB evidenced in the May minutes and the Briefing Note of 8 July 2013 would not have been actioned without approval of the Minister who ultimately announced on 6 August 2013 that closure would happen on a date in the future once certain things had happened.

28. The fact that the Minister announced it and announced it in terms that showed he claimed ownership of it[12] indicates that he considered himself actively involved in the decision. It was a matter proposed and recommended by the WMHHB which the Minister ultimately approved.

29. Dr O'Connell finished in his role as Director General of Queensland Health 9 days after the announcement was made on 6 August 2013 and the BAC did not then close its doors until January 2014. The closure was not legally affected until 29 August 2014, though no doubt it was appreciated that with the decision taken by the Board and the Minister it was a mere formality of attending to the paperwork.

THE CESSATION OF THE REDLANDS PROJECT

30. Since at least October 2008 it was the intention to move the BAC service to another site, with the preferred site having become Redlands.[13]

31. Dr O'Connell had understood the Redlands project was stopped by the briefing note signed by him in May 2012. Evidence heard in the Commission indicates that ultimately was not the case.

32. Dr O'Connell in his evidence stated that the decision to cancel the project was reached as an agreement between those ultimately responsible for practical application of state

[12] COI.008.0001.0002 transcript of announcement page 3 lines 2-6.
[13] Supplementary statement of Dr O'Connell page 5 paragraph 6.

and national mental health policy: that is, the Minister of the day following the receipt of advice from the Director General who in turn received advice from the relevant Deputy Directors General, the Chief Health Officer and the local hospital group. [affidavit of Dr O'Connell page 7]

33. Dr O'Connell in cross-examination said that he had the authority to sign off on the cancellation of the Redlands project [T12-15 line 24]. Cabinet was however kept updated on how capital projects were progressing. He also said that the Minister could veto any decision he made because ultimately it was the Government that set the policy. The Director General has the power to stop a project but the Director-General allowed Government via the Minster to veto that decision before it is promulgated. [T12-54 lines 32-43] The Minister in cross-examination agreed with this position. [T15-38 lines 36-39, 42-43 and T15-39 lines 8-11 and T15-41 lines 12-13]

34. The cabinet-in-confidence document[14] referred to the Queensland Plan for Mental Health 2007-2017 and queried whether deferring the Redlands 15-bed adolescent extended treatment unit funded under stage 1 of the QPMH was an option. There were three reasons given for deferral: multiple delays to date; estimated budget overrun of $1.46m; and recent sector advice. Dr O'Connell said in cross-examination that the information regarding budget and delays was likely to have come from the Deputy Director General responsible for infrastructure, Dr John Glaister.[15] The proposal from the sector that there might need to be a re-scoping of the clinical service model would have come from the Mental Health Branch.[16] The potential cost saving of not proceeding with the project was $15.15m in capital and $1.82m in recurrent operating costs.

[14] DPC.005.001.0001 and DPC.005.001.0002 pages 24-25.
[15] T12-17 lines 37-40.
[16] T12-17 lines 40-41.

35. Dr O'Connell said in cross-examination in relation to the QPMH that it is worth noting it was a 10 year plan that was promulgated in 2008. He said that any plan that goes for 10 years is at risk of being altered because the financial environment can change. [T12-20 lines 19-23]

36. Dr O'Connell in his affidavit at paragraph 10 cited six reasons for deciding to cease the Redlands project:

(a) extended land acquisition timeframes which meant that the timely and efficient running of this capital project was compromised;

(b) delays in confirming the model of service delivery to inform project definitions and schematic design;

(c) challenges with the low-lying site at a time of sensitivity to health facilities being flood-prone;

(d) budgetary constraints;

(e) the requirement to complete a preliminary infrastructure plan for the site under the requirements of the Sustainable Planning Act 2009 Community infrastructure designation or CID process requiring Queensland Health to meet vegetation protection and koala conservation state planning regulatory provisions; and

(f) most importantly, emerging clinical preference to care for patients currently treated at the BAC in a more community-based, closer-to-home model of care rather than an institutionalised model.

37. Paragraphs a, b, c and e can be described as "delays" past and prospective; d is referable to cost overruns in the context of a gloomy fiscal situation; f is the "contemporary model of care" issue.

38. By the 3 May 2012 Briefing Note[17] the Chief Health Officer sought the Director General's approval for cessation of the Redlands project. That briefing note was signed and approved by Dr O'Connell on 16 May 2012. It followed a consistent pattern supported in other documents and statements as to the relevant issues of concern. The May Briefing Note sets out the "headline issues" as being:

(a) multiple delays to the Redlands Adolescent Extended Treatment Unit capital program, a budget overrun of $1,461,224 and recent sector advice that proposes a re-scoping of the clinical service model and governance structure of the unit;

(b) an anticipated capital funding shortfall of $3.1 million for regional mental health projects which is proposed to be funded through cost savings resulting from the cessation of the 15 bed RAETU which had been funded under stage 1 of the Queensland Plan for Mental Health;

(c) inequities that existed for remote and rural consumers.

39. The reasons for ceasing the project were bundled together differently but a comparison of Dr O'Connell's reasons, the May Briefing Note, the evidence of Dr Cleary and Dr Kingswell and documentary evidence such as the Cabinet-in-confidence document[18] demonstrate a consistency in the reasons, none of which are overstated, as detailed below.

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[17] DBK.001.001.0032

[18] See Dr Kingswell at T13-5-T13-9. and Dr Cleary in his affidavit at page 7 paragraph 27 and DPC.005.001.0001; Springborg cross-examination T15-38 lines 36-43 and T15-39 lines 8-11.

40. The decision by Dr O'Connell purported to reallocate the funds to other important mental health care needs.[19]

41. As it happened however, and despite Dr O'Connell being now unaware of it, the decision made by him by signing the May Briefing Note was not actioned. Consistent with the practice established by the Minister, the decision was to go to him for noting, allowing him to veto it.

42. An email exchange on 25 June 2012[20] showed the decision was still awaiting approval by the Minister. A further email exchange on 9 July 2012[21] showed it remained there as at that date. Ultimately, the briefing note of 10 August 2012[22], initiated by the Minister's office, reallocating the funds to different projects, was signed off by the Minister. The inescapable implication is that the May decision was not actioned but a separate decision to cease the project in favour of funding other projects was made by the Minster with his signing of the August Briefing Note.

Budgetary constraints

43. Dr O'Connell said in his cross-examination: "*the Newman Government had come into power and we had a commission of audit which had identified that there had been allocated to it for the previous two years and that it was necessary to reduce both operational spending and capital spending to stay within the budget that was allowed.*" [T12-12 line 30-35]. He was being asked to identify $100 million in savings by the end of the financial year. [T12-18 lines 5-11]

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[19] Evidence of Dr O'Connell T12-58 lines 6-9.
[20] COI.027.0002.0001 - .0003
[21] QHD.008.002.9853
[22] QHD.006.005.2343 -.2347

44. Budgetary constraints seem to have been the precipitant to the decision to cease the Redlands project in the face of growing obstacles to the project proceeding. The need for financial restraint was what made decision makers look around to see where savings could be made.

45. The Redlands project was plainly going to cost even more then the estimated budget overruns had already taken into account, as a result of the further delays and redesign required discussed below. Estimates of overruns were based on the old design which was going to need to be reworked in any case.

46. Dr O'Connell in May and Dr Jeanette Young in August were looking at ways to reallocate the funds from Redlands. The money did not go back into consolidated revenue. Rather, in the competition for available funds under budgetary pressure, the money went back into the "pot" available for other projects. There was no prospect of an increase in funds to fulfil the suite of services hoped to be achieved to replace the BAC and the Redlands project. Whilst budgetary constraints were in all likelihood the precipitating factor, they were not the only or even the determinative factor, however, in the selection of this project as one to cease work on.

Delays

47. A Briefing Note to the then Minister for Health, Geoff Wilson dated 22 October 2010[23] relevantly asked that the Minister note that 23-31 Weippin Street Cleveland had been partially assigned to the relocation of the 15 Bed Adolescent Extended Treatment Unit. The Department sought to delay the Community Infrastructure Designation (CID) process until the Preliminary Infrastructure Plan (PIP) for the Redland Hospital site had been completed. It was noted that there would be a requirement to meet the Koala

[23] WMS.6006.0002.54301

Conservation State Planning Regulatory Provisions. It noted that the *Sustainable Planning Act* 2009 CID process required Queensland Health to meet the Koala Conservation State Planning Regulatory Provisions. It noted that the final Flora and Fauna Report was provided to Queensland Health on 18 November 2010 and had been used to inform the architect on Schematic Design for the Adolescent ETU to minimise koala habitation impacts while maintaining service functionality. The Note further stated that responses by the Department of Environment and Resource Management indicated concerns about the location of the Adolescent ETU at the back of the site in a denser koala habitat.

48. By letter dated 28 April 2011[24] the Department of Environment and Resource Management advised Janette Rowe from Project Services, Department of Public Works that in order to meet the outcomes of the State Planning Policy 2/10: Koala Conservation in SEQ, DERM recommended the following:

(a) DPW should identify all non-juvenile koala habitat trees;

(b) Queensland Health should consider making substantial changes to the design, layout and location of the proposed development to significantly reduce impacts on koala habitat such as:

(i) relocating all or part of the proposed facility;

(ii) realigning the development footprint further to the south where the density of koala habitat was less;

(iii) utilising areas of the site mapped as habitat suitable for rehabilitation;

[24] WMS.6006.0002.5455

(iv) removing or reducing the proposed open space areas;

(v) removing unnecessary road and/or ancillary infrastructure such as the roundabout;

(vi) reducing car parking facilities;

(vii) utilising open areas between the proposed car park and buildings;

(viii) redesigning the development layout.

(c) Queensland Health should provide more details about the proposed helipad and should consider locating it elsewhere;

(d) Koala habitat trees be used in appropriate areas of landscaping;

(e) Queensland Health should contribute part of the offset obligation to onsite rehabilitation and revegetation;

(f) A detailed offset commitment plan should be provided along with details of koala friendly fencing and details of traffic mitigation measures.

49. Table 4C prepared by Counsel Assisting at item 6 appears to focus only upon (f) which misreads the letter as if that was the conclusion or summary of its contents.

50. Politely worded as this response was, it in truth was saying to Queensland Health, "start again." This letter was of course a response to a "feeling out" of DERM as to what might be expected if a formal application was made to the Minister for an exemption from the scheme. In essence, the response was to suggest an application of the kind then proposed would be rejected on substantial grounds. It made no promise that, if the project could be appropriately redesigned, that it would be approved.

51. Consistent with the advice of 28 April 2011, the Briefing Note of 24 January 2012[25] indicated that a whole new Master Plan needed to be developed. The Briefing Note, signed by Executive Director and the Program Director of the Capital Delivery Program South, Health Planning & Infrastructure on 6 February and 14 February respectively notes at paragraph 13: "*The CID was recommenced in November 2011 with completion due in mid 2012. CID is required for the entire Redland site. And accordingly a complete new Master Plan for the Hospital across Lots 29 and 30 was required to be prepared for and endorsed by the district for inclusion in the CID submission. As required by legislation a further briefing note will be provided seeking ministerial approval of the CID of Redland Hospital including Lot 30 Weippin Street Cleveland.*"

52. Drainage was another issue that had caused delay to the Redlands project. It cannot now be regarded as resolved in 2009, for three reasons:

(a) as a result of the koala corridor, it was apparent that the whole project had to be redesigned in terms of changes to the buildings and location of the buildings on the site. The ongoing utility of the supposed solutions from 2009 are unknown in the context of such necessary dramatic revision;

(b) between 2009 and when the decision to cancel the project was made, there had been significant flood events, not the least of which was the 2011 Brisbane floods, resulting in changes to attitudes, practices and planning schemes of local authorities as well as government departments concerning flood-prone projects[26];

[25] QHD.004.014.8378
[26] See also cross-examination of Dr O'Connell regarding flood prone sites T12-11 lines 3-17.

(c) no evidence (from anyone in Infrastructure or otherwise) was called in any positive way to indicate that drainage or flooding or water courses were not an issue in 2012.

53. It is clear that the multiple delays with the Redlands project involving the koala corridor and drainage issues, in addition to the budget overrun already accumulated, could reasonably have rendered the project unworkable.[27]

54. The Commission has not had the benefit of a statement or oral evidence from any person with actual hands on responsibility for the building or planning issues for this project. Professor Crompton was led through some minutes of some meetings[28], some of which he was not at. He also told the Commission there was a sub-committee of experts that looked after these issues. He appeared from his answers to the leading questions about the meaning of the minutes not to have personal knowledge about the challenges of koalas and drainage.

Model of Care

55. Dr O'Connell was aware of an "emerging clinical preference" to care for patients in community based services rather than in institutions. He developed this awareness based on numerous conversations over the last two decades with adult and child psychiatrists and based on documents he had read, authored by mental health specialists. One of these documents is the QPMH 2007-2017 which stated: "A stronger role is envisaged for community based care and support." Another was the Richmond Report written in 1983 for the NSW Department of Health which was about "*redressing the imbalance between institutionalized hospital care and community care*

[27] DPC.005.001.0001 Cabinet in Confidence document states that deferring the Redlands project is an option.
[28] See cross-examination of Professor Crompton from T7-3 to T7-10.

in mental health services while advocating strongly for a more decentralized and integrated model of care and support." It also said: "*under the report some institutions were targeted for closure but not before both growth and compensatory community services were provided.*" Dr O'Connell however said in his supplementary affidavit "*I have not suggested that there is never a need for certain mental health patients to be hospitalized (acutely or in extended bed-based care).*"

56. With respect, the submissions of Counsel Assisting on the issue of "contemporary models of care" are guilty of the errors that they criticise others as having made.

57. Close examination and analysis of the evidence before the Commission shows that there has been, in those submissions, an eliding of different issues pertaining to models of care.

58. When the witnesses who have given evidence about a motivation to make decisions, whether it be to terminate the Redlands Project or to close the Barrett Adolescent Centre, spoke of "contemporary models of care", they were, it seems, speaking specifically about the provision of the relevant services at locations geographically proximate to where patients had come from.[29] They were not addressing the types of therapy employed, the design of the facility or even so much about the length of stay.

59. It is true, of course, that the committee chaired by Professor Crompton had worked to develop what might be thought to be a "contemporary model of care". However, that committee had not been charged with the task of determining whether a single,

[29] See Dr O'Connell's evidence at T12-6 lines 33-36, T12-10 lines 9-13, T12-13 lines 1-7, T12-23 lines 5-8, T12-39 lines 28-36; and evidence of Dr Cleary at T14-8 lines 20-23, T14-9 lines 27-43, T14-10 lines 37-42,T14-41 lines 39-43.

centralised, State-wide service was appropriate. Rather, the brief to it effectively instructed it to develop a model of care within such a facility.[30]

60. The reason for that presumption is not particularly clear, however the brief plainly was to arrange for a "replacement" of the BAC or a "relocation" of the BAC. The likely reason for the course followed is the Plan for Child and Adolescent Services Development by Dr Groves in 2006 based on information preceding it (see WMS.9000.0001.00001 at .00166). It was acceptable for there to be a restructuring of the model of care within that constraint but no latitude apparently was even contemplated for an examination by his committee as to whether it was appropriate to continue with the single State-wide service.

61. When it is recognised that it was with respect to that feature of the model of care, the evidence establishes that it was notorious amongst not only psychiatrists, but medical practitioners and administrators alike, that contemporary models of care required providing medical services including extended treatment and rehabilitation services for adolescents as close to their communities as was possible, it is inevitable that the conclusion must be reached that a service provision designed without any attempt to determine if the services could be provided in a more geographically diverse way, was not contemporary.

62. The shortcoming in the analysis of Counsel Assisting is presuming, when the evidence is in fact against it, that the model of care development done by Professor Crompton's committee, addressed that issue.

63. Whilst there is some debate as to whether the BAC service fitted within a contemporary model of care or not, or whether what might have been done at Redlands would have

[30] Statement of Professor Crompton MSS.900.0002.0001 paragraph 34.

been a contemporary model of care, Dr O'Connell given his role, qualifications and experience was entitled to rely upon advice from the likes of Dr Kingswell. Indeed that is why people are employed in such roles. Further, when the advice is consistent with well established principles in mental health care, especially concerning adolescents, it was all the more reasonable for him to do so. A number of eminent people have professed varying views. There is a substantial body of opinion now and then that is consistent with the views upon which Dr O'Connell acted.[31] It can hardly be said that it was unreasonable to endorse that conclusion bearing in mind that each of the decisions to cease the Redlands project and to close the BAC were not of themselves decisions to do that and nothing more: but rather were decisions to cease something and provide something else and to keep providing a service in the interim, pending the new service or services being available.

Conclusion regarding Redlands

64. Dr Jeanette Young who was Acting Director General at the time, signed the Briefing Note on 17 August 2012,[32] which recommended the cessation of the Redlands project in order for those funds to be put towards funding for 12 rural hospitals.

65. The decision to cease the Redlands project was then ultimately approved by the Minister for Health, Lawrence Springborg on 28 August 2012 in order for funding for 12 rural hospitals to be approved.[33]

66. Counsel Assisting have submitted at paragraph 210 of their closing submissions that "*the statement of fact that Redlands had ceased because of 'unresolvable building and*

[31] Evidence was given by a number witnesses that the number of patients in Queensland who require a medium to long term bed-based service is likely to be very small: Brett McDermott T7-44 lines 43-46; Lesley Dwyer T31-35; Dr Fryer T25-20 lines 43-45 and T25-21 lines 10-11; Professor Kotze T23-12 lines 13-22.
[32] QHD.006.005.2344
[33] QHD.006.005.2343

environmental barriers' is not supported by any evidence." This is simply not the case. There is a consistent thread in the documentation that supports the proposition that the Redlands project was becoming an expensive and unworkable project.

67. Dr O'Connell was left with the choice of persisting with the pursuit of a project that was uncertain to be finished, was uncertain to be funded and that appeared may not provide the right model of care or, Dr O'Connell could choose to reallocate the money to other projects that were also very important and appeared to be ready to be progressed.

68. In those circumstances, Dr O'Connell remained confident that signing the Briefing Note recommending the cessation of the Redlands project was consistent with his objective of securing the best interest of patients.[34]

69. Once it was decided that the Redlands project would not proceed, if there were to be any new services developed to treat the type of patient who would have been admitted to the BAC, that would have been the responsibility of the WMHHS together with the CHQHHS with input from the MHAODB. The authority to establish an alternative tier 3 service would therefore belong to the HHSs in consultation with the Department.[35]

70. As to the submission about the lack of a supporting report, it is to be noted that the version of the document signed by O'Connell had been "verified" by Dr Young on 12 May 2012. It was noted in terms of "urgency" to be "critical" as it was needed to support a CBRC submission that was to be submitted in the week beginning 14 May 2012. Dr O'Connell signed it on 16 May 2012. It was authored by the second most senior officer in the Mental Health Branch (Dr Geppert), cleared by the Executive

[34] T12-58 lines 23-30.
[35] Affidavit of Dr O'Connell paragraph 15.

Director (Dr Kingswell) and was verified by the Chief Health Officer. It identified issues that were not of a surprise to Dr O'Connell as they had been discussed over time.[36] Those problems did not it seems emanate from one source – they were infrastructure and clinical. It was plainly reasonable in circumstances of urgency (bearing in mind too the financial management pressures) for Dr O'Connell to sign off on it.

71. Retrospective forensic analysis has a tendency to overlook context. It is noted Dr O'Connell was operating a very big operation with very many employees over very many facilities[37] providing no doubt literally millions of health services every year, many of them involving very grave and serious implications. He would see no doubt thousands of documents providing instruction every year and a substantial number of briefing notes every week.[38] To retrospectively isolate one document in the context described above as requiring specific interrogation is unrealistic. Its practical correction would likely be paralysing for the office of the Director-General. If the advice upon which it was based was wrong, the criticism lies elsewhere.

THE DECISION TO CLOSE THE BAC

72. Counsel Assisting say in the Discussion Paper that the decision to close the BAC was a staged process.

73. The terms of reference however focus on "the closure decision" announced on 6 August 2013.

[36] See cross-examination of Dr O'Connell T12-18 lines 42-45.
[37] See cross-examination of Dr O'Connell T12-14 lines 23-32.
[38] Dr O'Connell said he received dozens of briefs every week in the role. T12-14 lines 45-46.

74. A briefing note dated 26 October 2012[39] was drafted and forwarded to the Deputy Director General, Dr Michael Cleary whereby the WMHHS Mental Health Service Executive Director sought approval from the WMHHB for closure of the BAC in December 2012. The "headline issues" on the Note were that service delivered through the BAC could not continue due to:

(a) the age and condition of the building which had been identified by the Australian Council on Healthcare Standards as unsafe, necessitating urgent replacement;

(b) concerns that had been raised about the co-location of BAC with adult forensic and secure services delivered by the Park Centre for Mental Health;

(c) clear policy direction to ensure that young people are treated close to their homes in the least restrictive environment with the minimum possible disruption to their families, educational, social and community networks;

(d) the average bed occupancy rate for BAC was 43% which was less than half of the 15 beds currently available in the unit.

75. This October Note however, as indicated earlier, was not actioned. Changes were requested by the Deputy Director-General, Dr Michael Cleary.

76. Following the decision subsequently taken by the WMHHS Board on May 2013, a briefing note for noting was provided by WMHHS executive to Dr O'Connell for his noting (rather than for his approval[40]). What the briefing note described was:

(a) by paragraph 1, it was important to be able to give information about the future of the BAC;

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[39] QHD.004.013.9670
[40] See submissions of Counsel Assisting at paragraph 234.

(b) by paragraph 2, having considered the ECRG report, the WMHHS Board had resolved to close the BAC:

(i) once there were appropriate alternate care provisions in place; and

(ii) in effect, if the Minister approved.

(c) by the attached proposed service elements document, headed "Barrett Adolescent Strategy Expert Clinical Reference Group", it was said that the BAC could not continue to operate at The Park because:

(i) services were to be decentralised;

(ii) The Park was only to be offering adult forensic and secure mental health services;

(iii) the building was in need of "substantial refurbishment".

(d) The ECRG acknowledge that "non acute bed based services should be community based wherever possible." There was a way forward which did include the provision of a design specific and clinically staffed bed based service. In any case, the representation in the "headline issues" of the briefing note by WMHHS that the closure was dependant on alternative, appropriate care provisions being in place, an outline of which was described in the attachment, made the note for noting quite unremarkable. The devil ultimately was to be in the detail of the planning and in the execution of that planning, the responsibility for which was to be shared, as noted in paragraph 11, by WMHHS, CHQ and QH (no doubt, specifically the Mental Health Branch)

The ECRG report

77. The ECRG report (or an adapted version of it) was attached to the July Briefing Note. Dr O'Connell did not recall seeing the attachment but gave evidence that he would have read it as that was his practice when a document was attached to a Briefing Note that was relatively short in length as this one was. [T12-7 lines 26-30]

Forensic adult unit at the Park

78. As to the relevance of the adult services provided and to be provided at The Park, the evidence canvassed for a slightly different purpose (ie the issue of urgency) by Counsel Assisting at paragraphs 430 to 441 is noted.

79. Mr Padraig McGrath, Nursing Director at the Park from March 2012 until June 2015, in his cross-examination cited that risks of co-location of BAC and an adult forensic unit included general vandalism, people accessing the site after hours, people driving at high speed through the grounds, attempting to sell illicit drugs and the fact that the BAC cohort included teenage female patients. [T19-12 lines 5-13]

80. Evidence was given about what some had done to allay concerns or diminish the risk of having the adult forensic unit adjacent to the BAC. Dr Sadler spoke about warning adolescents to take care when they went outside of the grounds, to go the canteen in pairs for example.[41] Dr Brennan gave a directive that no adolescents were to be allowed any ground leave unless they were in sight of a staff member.[42] Such instructions were the limit of what the Directors could do to mitigate the risk. Sharon

[41] T17-23 lines 5-8.
[42] T20-10 lines 36-41.

Kelly knew there was a risk.[43] Dr Kingswell recognised that if that risk had ever become reality the consequences could have been "catastrophic".[44]

81. The relevance to the decision to close the Barrett Adolescent Centre of the co-location of the adult forensic facilities at The Park ought be scrutinised through the prism of the Work Health and Safety Act 2011.[45]

82. WMHHS plainly was a "person conducting a business or undertaking" within the meaning of s. 5 of the Act.

83. The BAC was a "workplace" within the meaning of section 8.

84. By s.17 it was provided:

> "*Management of risks*
>
> *A duty imposed on a person to ensure health and safety requires the person— (a) to eliminate risks to health and safety, so far as is reasonably practicable; and (b) if it is not reasonably practicable to eliminate risks to health and safety, to minimise those risks so far as is reasonably practicable.*"

85. We pause to emphasise that the priority in management of risks then is to eliminate them, and only if not reasonably practicable to eliminate them, to minimise the risks so far as is reasonably practicable.

86. Section 18 provided:

> "*What is reasonably practicable in ensuring health and safety*
>
> *In this Act, reasonably practicable, in relation to a duty to ensure health and safety, means that which is, or was at a particular time, reasonably able to be done in relation to ensuring health and safety, taking into account and weighing up all relevant matters including—*
>
> *(a) the likelihood of the hazard or the risk concerned occurring; and*

[43] T11-70 lines 32-38 and T11-72 lines 11-23.
[44] T13-20 lines 1-4 and T11-74 lines 18-25
[45] Reprint as at 7 June 2013.

(b) the degree of harm that might result from the hazard or the risk; and

(c) what the person concerned knows, or ought reasonably to know, about—

(i) the hazard or the risk; and

(ii) ways of eliminating or minimising the risk; and

(d) the availability and suitability of ways to eliminate or minimise the risk; and

(e) *after assessing the extent of the risk and the available ways of eliminating or minimising the risk, the cost associated with available ways of eliminating or minimising the risk, including whether the cost is grossly disproportionate to the risk.*"

87. With respect to duties to the adolescents of the BAC, as opposed to the staff, s.20 was the operative provision and it provided:

"*Duty of persons conducting businesses or undertakings involving management or control of workplaces*

(1) In this section, person with management or control of a workplace means a person conducting a business or undertaking to the extent that the business or undertaking involves the management or control, in whole or in part, of the workplace but does not include—

(a) the occupier of a residence, unless the residence is occupied for the purposes of, or as part of, the conduct of a business or undertaking; or

(b) a prescribed person.

(2) The person with management or control of a workplace must ensure, so far as is reasonably practicable, that the workplace, the means of entering and exiting the workplace and anything arising from the workplace are without risks to the health and safety of any person."

88. Sections 274 and 275 provide for codes of practice. Those provisions state:

"*Approved codes of practice*

(1) The Minister may approve a code of practice for the purposes of this Act and may vary or revoke an approved code of practice.

(2) The Minister may only approve, vary or revoke a code of practice under subsection (1) if the code of practice, variation or revocation was developed by a process that involved consultation between—

(a) the Governments of the Commonwealth and each State and Territory; and

(b) unions; and

(c) employer organisations.

(3) A code of practice may apply, adopt or incorporate any matter contained in a document formulated, issued or published by a person or body whether—

(a) with or without modification; or

(b) as in force at a particular time or from time to time.

(4) An approval of a code of practice, or an instrument varying or revoking an approved code of practice, has no effect unless the Minister gives notice of its making.

(4A) A notice under subsection (4) is subordinate legislation.

(4B) A code of practice, or an instrument varying or revoking a code of practice, commences on the later of the following—

(a) the day the notice under subsection (4) commences; or

(b) the day the code or instrument provides that it commences.

(5) As soon as practicable after approving a code of practice, or varying or revoking an approved code of practice, the Minister must ensure that notice of the approval, variation or revocation is published in a newspaper circulating generally throughout the State.

(6) The regulator must ensure that a copy of—

(a) each code of practice that is currently approved; and

(b) each document applied, adopted or incorporated, to any extent, by an approved code of practice; is available for inspection by members of the public without charge at the office of the regulator during normal business hours.

Use of codes of practice in proceedings

(1) This section applies in a proceeding for an offence against this Act.

(2) An approved code of practice is admissible in the proceeding as evidence of whether or not a duty or obligation under this Act has been complied with.

(3) The court may—

(a) have regard to the code as evidence of what is known about a hazard or risk, risk assessment or risk control to which the code relates; and

(b) rely on the code in determining what is reasonably practicable in the circumstances to which the code relates.

Note— See section 18 for the meaning of reasonably practicable.

(4) Nothing in this section prevents a person from introducing evidence of compliance with this Act in a way that is different from the code but provides a standard of work health and safety that is equivalent to or higher than the standard required in the code."

89. Approved in 2012 as a code of practice under the Act was the "How to Manage Work Health and Safety Risks Code of Practice" published by Safe Work Australia in December 2011.

90. On page 13, s.4.2, there is discussion of the hierarchy of risk control. This describes the ways of controlling risks ranked from the highest level of protection and reliability to the lowest. It notes that the regulations require duty holders to work through that hierarchy when managing risk.

91. As the document sets out, the most effective control measure is to eliminate the hazard and associated risk. The best way to do that is by not introducing the hazard into the workplace.

92. The second most effective control measure involves substituting the hazard with something safer, isolating the hazard from people or using engineering controls. Relevantly here, by way of example, that might include fencing, though plainly there may be some negative implications of setting up such barriers around the BAC. The third but least effective method of managing risks is described as being "administrative actions". These are work methods or procedures and would cover, relevantly here, instructions to staff that adolescents were not to be allowed on the grounds outside of the BAC itself unless they were within eyeshot of a staff member or administrative

action in the form of screening processes of patients in the adult forensic facilities, or warning people to be careful.

93. Several other matters appear from the Code.

94. Firstly, hazards and their associated risks may be informed by history or absence of history of the occurrence but that cannot be exclusively relied upon. Hazards may be identifiable by a visual inspection of the workplace and a consideration of how risks might arise.

95. Secondly, risks are not selected to be managed solely on the basis of the likelihood of their occurrence. The potential seriousness of the consequences if the risk was to occur is a most relevant consideration as well as is frequency. The evidence of Professor McGorry and of Dr Neillie referred to by Counsel Assisting, needs to be read in these contexts.

96. Thirdly, a time of change at the workplace is a time for appraisal of hazards and risks that might arise. The introduction of EFTRU was such a circumstance.

97. The Work Health and Safety Regulation 2011[46] also contained relevant provisions imposing obligations on WMHAS.

98. Sections 32 to 36 are relevant. They provided:

> "***32 Application of pt 3.1***
>
> *This part applies to a person conducting a business or undertaking who has a duty under this regulation to manage risks to health and safety.*
>
> ***33 Specific requirements must be complied with***
>
> *Any specific requirements under this regulation for the management of risk must be complied with when implementing the requirements of this part.*

[46] The version as at 1 July 2013 is referred to.

Examples—

- *a requirement not to exceed an exposure standard*
- *a duty to implement a specific control measure*
- *a duty to assess risk*

34 Duty to identify hazards

A duty holder, in managing risks to health and safety, must identify reasonably foreseeable hazards that could give rise to risks to health and safety.

35 Management of risk

A duty holder, in managing risks to health and safety, must—

(a) eliminate risks to health and safety so far as is reasonably practicable; and

(b) if it is not reasonably practicable to eliminate risks to health and safety—minimise those risks so far as is reasonably practicable.

36 Hierarchy of control measures

(1) This section applies if it is not reasonably practicable for a duty holder to eliminate risks to health and safety.

(2) A duty holder, in minimising risks to health and safety must implement risk control measures under this section.

(3) The duty holder must minimise risks, so far as is reasonably practicable, by doing one or more of the following—

(a) substituting (wholly or partly) the hazard giving rise to the risk with something that gives rise to a lesser risk;

(b) isolating the hazard from any person exposed to it;

(c) implementing engineering controls.

(4) If a risk then remains, the duty holder must minimise the remaining risk, so far as is reasonably practicable, by implementing administrative controls.

(5) If a risk then remains, the duty holder must minimise the remaining risk, so far as is reasonably practicable, by ensuring the provision and use of suitable personal protective equipment.

Note— A combination of the controls set out in this section may be used to minimise a risk, so far as is practicable, if a single control is not sufficient for the purpose."

99. From the evidence it can be seen that there undoubtedly was a risk to the health and safety of adolescents at the BAC from its co-location with the adult facilities and, in particular, the new EFTRU facility being established. While similar risks had not eventuated in the past that was no answer to the workplace health and safety obligations imposed by law upon WMHHS. The hierarchy of controls that had to be brought to mind started with the most effective control, which was required to be implemented unless it was not reasonably practicable to do so, being to relocate the service provision of one or other of the facilities. That was the only way open to "eliminate" the risk.

100. As it was, there were only administrative controls (the least effective) ever in place to manage these risks. In the event the risk ever did eventuate, it is doubtful that those administrative controls would have protected WMHHS from a prosecution under the Act, let alone be justifiable as a morally adequate response.

GW Diehm QC

CJ Conway
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23 March 2016