Oaths Act 1867

Statutory Declaration

I, **Padraig McGrath**, c/- The Park Centre for Mental Health, Ellerton Drive, Wacol in the State of Queensland, do solemnly and sincerely declare that:

1 What are your current professional role/s qualifications and memberships? Please provide a copy of your current / most recent curriculum vitae.

1.1 My current professional role is Operational Director/Nursing Director of the Park Centre for Mental Health (**The Park**).

1.2 Attached and marked **PM-1** is a copy of my curriculum vitae which contains my professional roles, qualifications and memberships.

2 The Commission understands that you hold, or have previously held, the position of Nursing Director, Secure Services. With respect to this position:

(a) state the period during which you held this position.

2.1 In March 2012, I was appointed to the position or Nursing Director, Secure Services in an acting capacity.

2.2 In approximately April 2013, following an open applications process for that position, I was appointed to the role on a permanent basis.

2.3 I held that position until 30 June 2015 when the position was upgraded to the role of Operational Director/Nursing Director of The Park and I have held that position since that time.

(b) outline your key responsibilities in this position, including working and reporting relationships;

2.4 The key responsibilities in this position are the management of nursing staff and nursing services in the units for which I was responsible, responsibility for the nursing budget and general unit accountability for matters such as workplace health and safety and overall resource management.

2.5 The reporting relationship structure is that nursing staff report to a Nurse Unit Manager in the area in which they work, the Nurse Unit Managers report to a Nursing

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Director, and the Nursing Director reports to the Director of Nursing.

2.6 When I commenced in the role, the units in respect of which I had oversight responsibility were the High Secure Inpatient Service (HSIS), and the Barrett Adolescent Centre (**BAC**). Some time after I started, I was also allocated oversight responsibility for the Secure Mental Health Rehabilitation Unit (SMHRU) and the Extended Treatment and Rehabilitation (ET&R) and Dual Diagnosis service (which was to be phased out as part of the redevelopment plan for The Park).

(c) detail your role and responsibilities with respect to the operation and/or management of the Barrett Adolescent Centre (BAC); and.

2.7 My role and responsibilities with respect to the operation and/or management of BAC was the same as for the other units in respect of which I had responsibility. That is, my role was to:

(a) manage nursing staff and nursing services into BAC;

(b) ensure BAC was appropriately staffed;

(c) ensure the staff allocated to BAC were appropriately qualified; and

(d) responsibility for effectiveness of the nursing budget for BAC.

(d) provide a copy of your position description.

2.8 A copy of the Position Description for the role of Nursing Director, Secure Services is attached and marked **PM-2**.

3 The Commission understands that you hold, or have previously held, the position of A/Director of Nursing. With respect to this position.

(a) state the period during which you held this position.

3.1 I held the position of Acting Director of Nursing for a period of approximately three to four weeks in December 2012 when the then Director of Nursing, Will Brennan was on leave.

(b) outline your key responsibilities in this position, including working and reporting relationships;

3.2 At the time I held the position, the key responsibilities of the role of Director of Nursing was overall responsibility for the nursing workforce for The Park.

3.3 Following the structural changes to West Moreton Mental Health and Specialised Services introduced in 2013, the Director of Nursing role responsibility also included responsibility for the overall nursing staff in the Integrated Mental Health Service (**IMHS**), Community Mental Health Service (**CMHS**) and the Prison Mental Health Service, ie all units with West Moreton Mental Health Services. I was not in the role during this period but I reported to the role.

3.4 The reporting relationships of the role are that the Nursing Directors report to the Director of Nursing, and the Nursing Director reports to the Executive Director Mental Health and Specialised Services.

(c) detail your role and responsibilities with respect to the operation and/or management of the BAC; and.

3.5 The position of Director of Nursing has more responsibility for strategic planning and less operational involvement. In relation to the operation and/or management of BAC, at the time I held the position of Acting Director of Nursing, the Nurse Unit Manager of BAC reported to the Nursing Director, Secure Services who in turn reported to the Director of Nursing.

(d) provide a copy of your position description.

3.6 Attached and marked **PM-3** is a copy of the position description for the position of Director of Nursing.

Redlands

4 Were you involved in the planning of the 15-Bed Adolescent Extended Mental Health Treatment Unit at Redlands Hospital;? If yes, please provide details as to the nature of your involvement and the relevant date(s).

4.1 I was not involved in the planning of the 15 Bed Adolescent Extended Mental Health Treatment Unit at Redlands Hospital.

5 Were you involved in the decision to not proceed with the development of the 15-Bed Adolescent Extended Mental Health Treatment Unit at Redlands Hospital? If yes, please detail the reason(s) why this unit did not proceed, the source of that

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understanding, and when the decision was made and by whom.

5.1 I was not involved in the decision to not proceed with the development of the 15 Bed Adolescent Extended Mental Health Treatment Unit at Redlands Hospital.

5.2 I was aware at the time I commenced at The Park that a facility was to be constructed at Redlands to which the operations of BAC would be transferred. I was also aware that the project encountered environmental difficulties but I am not aware of the specific details of those. I had no personal involvement in any aspect of the project and my knowledge of it was solely from informal discussions with staff at BAC at the time.

5.3 I had no formal notification that the Redlands project was not going ahead. Again, this is something I heard about from discussions with nursing staff. At that time, the view of staff seemed to be that there had been previous intentions to close BAC which had not been followed through, and this had occurred again. I was not informed of specific reasons why the Redlands unit did not proceed or when or by whom that decision was made.

Closure of the BAC

6 On what date, how, and from whom, did you first become aware of the possibility of the BAC being closed?

6.1 I was aware from the time I commenced employment at The Park of the possibility of BAC being closed. At that time, it was my understand that a new facility was being built at Redlands for adolescent mental health services and that once that facility was commissioned, BAC would close because its operations would be transferred to the Redlands facility.

6.2 When the Redlands project was cancelled, I was not given any specific information as to what effect that might have on BAC.

6.3 On 9 November 2012, I received a telephone call from the Nurse Unit Manager of BAC who told me that she had been contacted by the media asking for comment because a public statement had been made by Dr Brett McDermott that BAC was being closed. At the time of that call, I was not aware of any immediate or definite plan to close BAC.

6.4 Later that day the Health Service Chief Executive, Lesley Dwyer, the Executive

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Director Mental Health and Specialised Services, Sharon Kelly, the Director of Nursing, Will Brennan and myself met with staff at BAC in response to Dr McDermott's public statement and the media interest it had caused. Staff were concerned and some were distressed at the media ringing the unit and some were distressed that an apparent public announcement of closure had been made without them being informed. Lesley Dwyer addressed the staff and my recollection is that she tried to reassure them that there was no immediate plan to close BAC but that how adolescent mental health services were being delivered and should be delivered in the future was under review.

6.5 At that point in time:

(a) I did not have any involvement in or awareness of what investigations or considerations were being undertaken by WMHHS.

(b) It was my belief that the principal decision maker in respect of any change would be the Mental Health Alcohol and Other Drugs Branch (**MHAODB**) and the Department of Health because this was a State-wide service and decision making in relation to State-wide services rested with the MHAODB and the Department not at the HHS level.

(c) Developing an alternative which involved transfer of BAC to another physical location, similar to the Redlands proposal, could not have been done in the short term because such projects typically require five to ten years in the planning and development.

6.6 Accordingly, my assumption at that point in time was that BAC would continue to operate as normal at least in the short term.

6.7 I recall that around this time Dr Sadler had talked to nursing staff at BAC about his own preferences and potential other options for the future of the service. In general, his preference was for BAC to be relocated to another building and continue in its current model of care. I have a recollection that he and at least one of the nursing staff visited Logan Hospital because it had beds in its acute mental health service which had not been opened and he wanted to consider whether those beds could be reconfigured to accommodate an adolescent service. I cannot now recall specifically how I became aware of this. It was most probably told to me by the then Nurse Unit Manager. I do not recall having any conversation with Dr Sadler about this.

6.8 In my opinion this would not have been a particularly good solution because the physical layout for an acute unit reflects the care needs of acute patients. Although there would be some common features, the needs of extended treatment and rehabilitation patients are different and therefore the physical requirements of the space are different. Any such option would have required the approval of MHAODB and acceptance by Metro South HHS.

6.9 In 2013 I became aware that alternative models of care to the one provided at BAC were being considered. I cannot recall with certainty but assume that I was informed of this by the Director of Nursing, Will Brennan and/or the Executive Director Mental Health and Specialised Services, Sharon Kelly. I do not recall being invited to or attending any formal meetings in that respect.

6.10 In about the middle of 2013, I recall nursing staff discussing the prospect of BAC not continuing to operate at The Park campus, that is either:

(a) BAC would relocate temporarily to another site while work was done to upgrade the BAC facility at The Park; or

(b) BAC would close permanently and the services be provided elsewhere.

6.11 Throughout this period, I met weekly or fortnightly with the Nurse Unit Manager at BAC to discuss general operational issues concerning the unit. The Nurse Unit Manager did not draw to my attention any specific concerns of staff regarding the future of BAC. To the contrary, the attitude seemed to be that "we've been through this before" and BAC had never been closed, so it would be the same this time. There was no change to the operational management of BAC during this period. It continued to accept, treat and discharge patients in accordance with its ordinary operating procedures.

6.12 During this period I was not formally consulted on my views in relation to whether BAC should remain operating or should be closed or the model of care changed. I cannot recall specific discussions but I would have had informal discussions on this topic with Will Brennan and Sharon Kelly from time to time.

6.13 On 6 August 2013 the Minister for Health announced that BAC would be closed. It was a broad statement which did not given specifics of the alternative models of care which would be put in place and from recollection it did not commit to a specific timing for the closure of BAC but early 2014 was mentioned.

7 Explain the extent of your involvement and/or input into the decision to close the BAC.

7.1 I had no involvement and/or input into the decision to close BAC.

8 In the event that you had direct involvement and/or input into the decision to close the BAC, provide details as to:

(a) the extent and/or nature of your involvement and/or input into the decision;

(b) the name and position of those other persons involved in the decision;

(c) the reasons for the decision to close the BAC;

(d) on what date the decision to close the BAC was made;

(e) any consultation with experts and/or stakeholders (and when), and the nature of the consultation;

(f) what advice/views were given by those experts and stakeholders prior to the decision, and how influential each of the perspectives was to the decision-making and/or your input into the decision to close the BAC;

(g) all alternative options and/or service models considered in making and/or having input into the decision to close the BAC;

(h) whether an alternative Tier 3 service ever formed part of the decision-making process with respect to the closure of the BAC (and if so, when), and the reason why an alternative Tier 3 service was not established;

8.1 Not applicable.

9 In the event you did not have any direct involvement and/or input into the decision to close the BAC:

(a) on what date, how and from whom, did you become aware of the decision to close the BAC;

9.1 I became aware of the decision to close BAC on or about 6 August 2013 when the Minister for Health made a public announcement of the decision.

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Padraig McGrath Witness

(b) detail your understanding as to the reason(s) for the decision to close the BAC (and the source of that understanding);

9.2 It was my understanding that there were three principal reasons for the decision to close BAC:

(a) BAC did not reflect a contemporary model of care for adolescent mental health treatment.

(b) The redevelopment of The Park into a State-wide adult forensic treatment facility meant that it was not appropriate to have a non-secure, non-forensic adolescent population on site.

(c) The BAC buildings and physical environment were a suboptimal therapeutic environment for an adolescent extended mental health service.

9.3 The source of my understanding that these were the reasons to close BAC was from discussions with the Director of Nursing, Will Brennan, the Executive Director Mental Health and Specialised Services, Sharon Kelly and discussions with nursing and other staff within BAC as to the challenges which the operating environment presented for them.

(c) detail your views as to the appropriateness of the decision to close the BAC;

9.4 In my view the decision to close BAC was appropriate.

9.5 In relation to the model of care:

(a) The concept of what constitutes a contemporary model of care depends to some extent on the personal opinion of psychiatrists within the sector. However, at a minimum, a model needs to be evidence based.

(b) The BAC model of care was not a model of care I had seen in place in any other mental health system in which I have worked. I am not aware of any substantial evidence based research which demonstrates it is an effective model of care.

(c) Contemporary models of care for adults comprise brief, intensive bed admission in acute unit where required with long term care largely delivered through outreach support in the local community to support the patients' long

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term needs. This philosophy underpins the changes at The Park in relation to adult non-forensic services. These considerations are the same, if not greater, in relation to adolescent mental health because for adolescents, peers provide a much more significant support network than is the case with adults. This means that significant emphasis should be placed on keeping adolescents close to their school, peer and other local community support networks.

(d) The benefit of maintaining adolescents as close to their local community as possible include:

(i) There is less stigma associated with the patient seeking treatment.

(ii) The prospects of reintegration back into the local community are optimised.

(iii) The patient has access to other services, some or all of which they will use on an ongoing basis post discharge.

(iv) Maintaining the connection and the support structures associated with school, home and peer group provides a better prospect of those networks being successful, as compared to trying to re-connect with those networks after an extended period away.

9.6 In my view, the isolated location of The Park campus was not the best therapeutic environment for this cohort of patients. With one exception, these were not forensic or secure patients and it is appropriate and therapeutically beneficial for them to be in an environment where they have easy access to social, educational and community activities as the aim of treatment is to enable them to return to living in the community.

9.7 BAC was in an isolated location, disconnected from community activities such as schools, shops and other activities which ideally patients ought to have been involved in, and encouraged to be involved in, to lessen the sense of institutionalisation.

9.8 As to the collocation issues, over a period of years a redevelopment program was in place in relation to the adult services at The Park. The plan involved The Park becoming a State-wide adult forensic patient service, with all non-forensic services to devolved elsewhere. This devolution of care involved:

(a) Closing the non-forensic adult services at The Park, which included the Dual Diagnosis unit and the Extended Treatment and Rehabilitation (ET&R) service.

(b) Construction of a Community Care Unit at Gailes to which some of these patients would be transferred, and on a State-wide basis the construction of Community Care Units in other locations which would receive some patients based on their community of origin.

(c) Development of an Extended Forensic Treatment and Rehabilitation Unit (EFTRU) as a step down service between the High Secure Inpatient Service (HSIS) and transition to a community based service.

9.9 There was a view, which I shared, that collocation of a cohort of vulnerable adolescent patients on the same campus as the forensic services was not appropriate. This is because:

(a) A large number of the forensic patients had committed serious offences and presented a risk potentially to the public but also to the particular profile of patients at BAC. This was particularly so with the development of EFTRU, because as a step down service this model of care afforded greater freedom to patients. Whilst a rigorous risk assessment process is used to gauge their suitability for greater freedom of movement etc, the risk of such a patient committing an offence or engaging in inappropriate behaviour cannot be completely eliminated.

(b) It is unfortunate but true that there is a level of stigma associated with mental health, and a greater level of stigma associated with a forensic service. Forensic services are known or assumed to be for patients who have committed serious offences, particularly offences of a violent or sexual nature. With The Park becoming a forensic only campus, BAC patients would have suffered an unnecessary level of stigma if the service remained on the campus.

9.10 In relation to the physical aspects of BAC, the facility was inappropriate to its intended purpose for a number of reasons:

(a) The building itself was old and in need of modernisation.

(b) More fundamentally, its layout presented challenges, for example:

(i) The layout did not easily accommodate staff undertaking observations of patients unobtrusively.

(ii) There were privacy issues associated with the fact that the majority of patients were in shared rooms and bathrooms were shared.

(iii) The building did not provide an appropriate mix of private spaces and areas where patients could socialise.

9.11 For those reasons, even if it was financially viable to refurbish the existing BAC buildings or even to build another building on The Park campus, those options would not have addressed the therapeutic shortcomings in the BAC model, the issue of the site being isolated from community activity, or the inappropriateness of co-locating the service with an adult forensic service.

9.12 Therefore I supported the decision to close the physical facility of BAC on the basis that there would be a move to a contemporary model of care for adolescents based on short term acute inpatient stays where necessary, supported by long term care in the community.

(d) how, when and to whom, you communicated the decision as to the closure of the BAC, and for what purpose;

9.13 I was not responsible for communicating the decision as to the closure of BAC.

10 Explain the extent of your involvement and/or input into the decision that the closure date for the BAC was to be early (January) 2014.

10.1 I had no involvement and/or input into the decision that the closure date for the BAC was to be early (January) 2014.

11 In the event you had direct involvement and/or input into the decision that the closure date for the BAC was to be early (January) 2014, detail:

(a) the extent and/or nature of your involvement and/or input into the decision and the name and position of those persons involved in making the decision;

(b) the reasons as to why early (January) 2014 was chosen for the closure of BAC;

(c) on what date the decision as to the closure date was made;

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(d) any consultation with experts and/or stakeholders (and when), and the nature of the consultation;

(e) what advice/views were given by those experts and stakeholders prior to the decision, and how influential each of the perspectives was to your decision-making and/or input into the decision;

(f) the existence of any flexibility with respect to the early (January) 2014 closure date, once set, or any review mechanisms; and;

(g) how, when and to whom, you communicated the decision as to the closure date.

11.1 Not applicable.

12 In the event you did not have any direct involvement and/or input into the decision that the BAC's closure date was to be early (January) 2014:

(a) on what date, how and from whom, did you become aware of the decision that the closure date would be early (January) 2014;

12.1 The Minister's press announcement on 6 August 2013 referred to potential closure in early 2014.

12.2 I recall becoming aware some time after about that time that January 2014 was considered to be a target date for closure. I was never informed of a particular closure date or that closure had to occur by a particular time. I do not believe there was a decision of a closure date of early 2014 or January 2014. This was a target and if all patients had not been appropriately transferred by then, BAC would have stayed open.

(b) any reasons communicated to you as to the reason for the closure date and from whom, by what means, and on what date; and

12.3 I do not recall any particular reasons being communicated to me as to the reasons for the closure date.

12.4 The decision to close having been made, the key issues in determining an appropriate closure date would, in my opinion, be the period of time required to safely and effectively transfer patients to other services and a sufficient lead time to

manage redeployment of staff.

12.5 Although I am unaware of specific reasons for January 2014 being targeted, I would say that:

(a) The majority of BAC patients go home to their families over the Christmas period. It is logical that it would be less disruptive for a patient to go home for Christmas and then transfer to another service, rather than going home for Christmas, returning to BAC for a period of time and then being on-transferred to another service. The timing would also coincide with the school year.

(b) It is reasonable to expect that closure of a unit like BAC would take a period of time given it is a longer stay unit and not all other HHS's have specialist mental health units so some logistical complexities would likely be expected in closing the unit.

(c) From a staffing perspective, a lead time would be necessary to go through an orderly process of redeployment and/or redundancies for staff who did not wish to accept redeployment or in respect of whom alternative roles could not be found.

(c) the extent to which you were aware of the existence of any flexibility with the respect to the closure date or any review mechanisms.

12.6 So far as I am aware, there was no closure date ever fixed for BAC and therefore no review mechanism required. It was my understanding that BAC would remain open until such time as all patients had been appropriately discharged or transferred to other services.

13 Did you consider the early 2014 closure date to be appropriate and the reasons as to why/why not?

13.1 The primary consideration for a closure date of BAC was always patient care. There was no early 2014 closure date as such, but rather the decision was that BAC would close when all patients had been effectively transferred. If for some reason there were still patients left as at January 2014, it was my understanding and expectation that BAC would stay open. There were sufficient staff available to manage BAC if that were necessary.

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13.2 Having said that, there are challenges involved in an open ended or long term closure timeframe. In particular:

(a) As the cohort of patients shrinks, the remaining patients are those with complex needs. Having a very small number of highly complex cases in a near empty facility is not therapeutically beneficial for those remaining patients. Coupled with the uncertainty of the future for them, it is therapeutically appropriate to attempt to finalise their transitions sooner rather than later.

(b) As with any unit, a closure announcement caused some staff to seek positions elsewhere, leading to some loss of collective knowledge of the patients and unit procedures due to the need to rely on casual nursing staff to carry through to closure of the unit.

(c) In addition, remaining staff tend to become disengaged because they know there is no future for the unit. This is not beneficial to good quality care for the patients, nor is it in the best interests of staff. This represents a further reason that, once closure has been decided, it should be implemented within a reasonable period of time.

13.3 Whilst January 2014 was never a fixed closure date, by at least early December 2013 I thought that a January 2014 closure date was likely to be appropriate and achievable because:

(a) I had weekly meetings with Acting Clinical Nurse Consultant, Vanessa Clayworth (discussed below) from which I was aware that she and Dr Anne Brennan were meeting regularly and doing very intensive, detailed work on transition plans on an individual patient basis. Based on what Ms Clayworth was reporting to me, it appeared to me that the transitions were progressing satisfactorily. By that time, there were sufficiently few patients left at BAC that I felt comfortable closure in about January 2014 would achieved.

(b) There had been a sufficient reduction in staff, commensurate with the drop in patient numbers, that I felt comfortable that processes to redeploy or otherwise manage the remaining workforce could be achieved within that timeframe, ie that it would not be necessary to leave BAC open because the issue of redeployment of staff had not been dealt with.

13.4 I went on leave at Christmas 2013. My understanding when I went on leave was that

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a closure date for BAC was still not locked in and the position was that if the remaining patients had not been able to be transitioned, BAC would still be operating. When I returned in late January 2013, all patients had been transitioned and BAC was closed.

14 Did you facilitate or attend any meetings regarding the closure of the BAC and, if so, with whom and on what date(s), and for what purpose?

14.1 On 9 November 2012 I attended at meeting of BAC staff which was called as a result of the media interest following a public statement by Dr Brett McDermott in connection with a child safety commission of enquiry, that BAC would close. The Health Service Chief Executive, Lesley Dwyer, the Executive Director Mental Health and Specialised Services, Sharon Kelly, the Nursing Director, Will Brennan and I met with BAC staff. Ms Dwyer addressed the staff as set out in paragraph 6.4 of my statement.

14.2 On 6 August 2013 I attended a meeting of BAC staff. Ms Dwyer, Ms Kelly, Mr Brennan and I attended to meet with the staff. The purpose of the meeting was to advise staff that the Minister for Health would be making an announcement that evening that BAC was to be closed.

14.3 As had been my practice from the time I commenced employment at the Park, I met weekly or fortnightly with the Nurse Unit Manager from BAC to discuss operational matters affecting BAC. In particular, these meetings dealt with operational needs of the unit in relation to staffing, equipment, maintenance etc, HR aspects of nursing staff management such as performance management, training and education requirements etc, and staff mix and staff profile related matters. These meetings were not specifically related to the closure of BAC but to the extent that the impending closure affected staffing issues, they may have been discussed in those meetings.

14.4 As was also my practice from the commencement of my employment at the Park, I had fortnightly or monthly meetings with the Workforce team in relation to workforce management issues across the units for which I was responsible. In the early period, this was principally in relation to changes to the workforce in the High Secure services. However, following the announcement of the closure of BAC, these meetings also included discussions relevant to redeployment, redundancy options etc for BAC staff. The discussions would have included monitoring staff numbers in

BAC, discussions about impending staff departures and whether vacancies created by staff departures needed to be filled (depending on remaining staff numbers, remaining patient numbers etc) and staff options for future employment.

14.5 The Workforce team had principal responsibility for dealing with individual staff about their redeployment or other future options. I facilitated meetings between the Workforce unit and individual staff members who wanted information or to explore their future options.

14.6 Vanessa Clayworth was appointed Acting Nurse Unit Manager on 5 August 2013. In about late September 2013, because we appreciated that the transition process would require additional resources, Ms Clayworth was offered the option of continuing as Acting Nurse Unit Manager or taking a role as Acting Clinical Nurse Consultant with responsibility in relation to transition of patients. She elected to take the Acting Clinical Nurse Consultant role and Alex Bryce was appointed Nurse Unit Manager. I met weekly with Vanessa Clayworth once she was appointed to the position of Acting Clinical Nurse Consultant to provide her with support as a professional senior in her new role.

14.7 Ms Clayworth's appointment was a Nurse Grade 7 position which meant that she was coming from a clinical position with little managerial component to a position which did include managerial responsibilities. My role was to provide professional supervision and advice on how to navigate these new responsibilities, for example assisting her to understand the scope of the operational accountability of the role, learning about when and how to escalate issues and assisting her to identify what was and was not within her scope.

14.8 The meetings were not for the purpose of my providing clinical advice on patients. It was more in relation to assisting her with process. For example if she told me that she was trying to get a particular patient into a particular accommodation arrangement but had not been able to achieve that, I would ask her what she was trying to achieve with the particular patient and to think about how else that might be achieved, rather than exploring whether the accommodation option she was attempting to pursue was the correct one for that patient. That would be a clinical decision for Dr Brennan, not an implementation decision for Ms Clayworth. Accordingly, if the issues she raised were clinical ones, I would counsel her about not making clinical decisions outside her scope of practice and discuss what was within her scope of practice and what she should take to Dr Brennan for clinical decision. It

was about teaching her how decisions are made and who has the carriage of particular decision making areas, rather than making any clinical decisions in relation to particular patients.

14.9 I had weekly meetings with the Director of Nursing, Will Brennan to discuss the KPIs and performance of the units for which I was responsible. This would have included conversations about BAC but were not specifically about BAC or its closure. Once closure was announced, those meetings would have included conversations about staffing similar to those that I was conducting with the Workforce team.

14.10 For approximately one month in late 2012, I acted in the role of Director of Nursing when Will Brennan was on leave. During that period I would have met fortnightly with the Executive Director Mental Health and Specialised Services, Sharon Kelly and those conversations would have included matters such as staffing levels and issues with staff across the park generally.

15 Detail any processes that you were involved in (or were otherwise aware of), with respect to communicating the closure decision to parents of BAC patients (and their families) and BAC staff, and the nature of your involvement (and when).

15.1 I was not involved in communicating the closure decision to parents of BAC patients and their families.

15.2 My involvement in communicating the closure decision to BAC staff was that I attended the meeting with BAC staff on 6 August 2013 at which Ms Dwyer communicated to staff that the Minister would be announcing the closure of BAC later that day.

Transition arrangements

16 During 2013 up until early 2014, a number of BAC patients were transitioned to alternative care arrangements in association with the closure or anticipated closure of the BAC (Transition Clients). With respect to the Transition Clients:

(a) detail your involvement in developing, managing and implementing the transition plans (including, but not limited to, identifying, assessing and planning for care, support, service quality and safety risks);

16.1 I was not involved in developing, managing or implementing the transition plans for BAC patients.

[redacted] [redacted]

.....

(b) identify the Transition Clients with whom you were involved;

16.2 I was not involved with any of the Transition Clients.

(c) if there were transitional plans in place for the Transition Clients;

(i) state who was responsible for preparing and overseeing the transition plans;

16.3 There was a transition team responsible for preparing and overseeing transition plans. The team was headed and supervised by Acting Clinical Director of BAC, Dr Anne Brennan. From a nursing perspective, Acting Clinical Nurse Consultant, Vanessa Clayworth was heavily involved with the preparation and implementation of transition plans. I understand that relevant allied health staff and case coordinators for individual patients were also involved in the preparation of transition plans but I am unaware of the specific details of this as I was not involved personally with the transition planning.

(ii) provide details as to how transition plans were developed, including but not limited to, any consultation(s) with Transition Clients and/or their families, friends or carers (and the date and detail of such consultation(s));

16.4 I was not involved with the development of transition plans and therefore I am unaware of the specific details of how they were developed. However, based on my weekly discussions with Ms Clayworth, I am aware that very detailed, individual plans were developed in respect of each patient in respect of their clinical needs and incorporating accommodation and lifestyle support needs.

16.5 I did not have any consultations with transition clients and/or their families, friends or carers in relation to transition plans.

(iii) advise whether there were any arrangements to review transition plans; and

16.6 I was not involved in reviewing transition plans. However, in my weekly meetings with Ms Clayworth, we would discuss if she was experiencing challenges with particular patient transition planning and I would give her advice as to how to address those challenges. I did not provide any clinical input as clinical decisions in relation

to individual patients was a matter for Dr Brennan. My input consisted of advice to Ms Clayworth as to the appropriate avenues to pursue to address challenges, for example if the issue was a clinical one, to speak to Dr Brennan.

16.7 Transition plans were also considered at the BAC Weekly Update Meetings some of which I attended. At those meetings, Dr Brennan would raise any challenges being experienced by the transition team and ways to address those challenges would be discussed and, if appropriate, actions allocated to address those challenges. For example, if the issue was one of funding, the Acting Director of Strategy, Dr Leanne Geppert would generally be tasked with progressing the matter because she had established networks with MHAODB and an understanding of funding processes.

(iv) outline what progress each client made in respect of the transition plans. If progress was unsatisfactory, what arrangements, if any, were made for alternative management;

16.8 I am not aware of the specific progress of individual BAC patients in respect of transition plans as I was not involved in individual BAC patient transition planning or implementation. In general terms, I am aware that:

(a) If challenges or blockages were experienced with transitioning a particular patient, it was the role of Dr Brennan to resolve because transition arrangements were a clinical decision for the treating psychiatrist. If Dr Brennan experienced challenges, she would escalate these through Dr Elizabeth Hoehn or up to Sharon Kelly.

(b) If the challenge was not clinical but rather was in relation to a structural issue such as funding, this would be escalated to Sharon Kelly or Leanne Geppert for resolution. The process for resolution followed the usual public service model which was that the appropriate person within WMHHS would contact their counterpart at the other HHS, and if that did not result in a solution, it would be escalated within WMHHS and the person to whom it was escalated would contact their counterpart.

(d) Outline any information, material, advice, processes, considerations and recommendations that related to or informed the transition plans.

16.9 I was not involved in the preparation of individual transition plans, but in general terms in relation to all patient plans:

[redacted] [redacted]