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 ANNE BRENNAN

1. Dr Brennan was Acting Clinical Director at the BAC from 11 September 2013 until 30 January 2014.

2. The terms of reference relevant to Dr Brennan are 3(d), (e), (f), (h) which state as follows:

> *"3(d) for BAC patients transitioned to alternative care arrangements in association with the closure or anticipated closure, whether before or after the closure announcement (**transition clients**):*
>
> *(i) how care, support, service quality and safety risks were identified, assessed planned for, managed and implemented before and after the closure (**transition arrangements**); and*
>
> *(ii) the adequacy of the transition arrangements;*
>
> *(e) the adequacy of the care, support and services that were provided to transition clients and their families;*
>
> *(f) the adequacy of support to BAC staff in relation to the closure and transitioning arrangements for transition clients;*
>
> *(g) -*
>
> *(h) without limiting paragraphs (d)-(g) above – the information, material, advice, processes, considerations, and recommendations that related to or informed the transition arrangements and other matters mentioned in paragraphs (d)-(g) above."*

3. The following issues are pertinent to Dr Brennan:

   (a) What is transition?

   (b) What is adequate transition?

   (c) Who were the "transition clients"?

(d) What were the "transition arrangements" for each "transition client"?

(e) Were the transition arrangements adequate?

(f) Was the care support and services that were provided to the families of transition clients adequate?

TOR 3(d) (e) and (h) TRANSITION ARRANGEMENTS AND ADEQUACY OF TRANSITION FOR TRANSITION CLIENTS

What is transition?

4. Most literature dealing with "transition" in relation to the care of adolescents accessing mental health services relates to transition from paediatric to adult services.

5. The BAC closure presented a situation where "transition" or transfer to a different service or services was necessary rather than being a transition process in the usual course.

What is "adequate" transition?

6. The Commission has had regard to reports and articles in relation to "transition". It can be fairly deduced from that material that there is no "perfect" method of transition nor is there much by way of analysis of success rates of transition. The outcome of a successful transition is maximisation of the young person's quality of life, through high quality, uninterrupted health care services, while the ultimate goal of transition is to facilitate the development of successful self-management in young people with chronic conditions.[1]

[1] Ipso-Eureka Social research Institute Report "Review of Transition of Young Adults" 28 October 2008 Melbourne

7. Some principles of good transition process for young people to adult care can be discerned from the literature[2] and summarised as follows:

(a) an attitude should be adopted that sees transition as a process rather than an event;

(b) the process should be systematic and formal transition (underpinned by formal guidelines and policies);

(c) early preparation;

(d) timing should be appropriate (i.e. don't attempt transition during a stressful period);

(e) identification of a transition coordinator/facilitator;

(f) good communication;

(g) development of individual transition plans;

(h) should be "patient-centred" involving young people and their families;

(i) should be co-ordinated and continuous involving a "team approach";

(j) managerial and administrative support should available;

(k) young people should be empowered, encouraged and enabled to self-manage (where young person has complex needs their family/carer will need to be involved);

(l) clear documentation should be provided to the receiving service consistent with privacy requirements.

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[2] ibid; and "Key Principles for Transition of Young People from Paediatric to Adult Health Care" published by NSW Agency for Clinical Innovation, Trapeze and the Sydney Children's Hospitals Network 2014.

(m) follow up and evaluation.

8. The Queensland Department of Health document "Guideline for the transition of care for young people receiving mental health services" produced in September 2015 after the Kotze report is a guideline for transitions from:

(a) CYMHS to an AMHS

(b) specialist and/or more intensive mental health service to a less intensive service (eg Evolve Therapeutic Services to a Community CYMHS;

(c) CYMHS to another CYMHS in a different geographical area

(d) CYMHS to GP or other primary health care provider, private practitioner or non-govt organisation.[3]

9. That Guideline therefore deals with more than transitions from paediatric services to adult services. It recommends: a systematic and formal transition process; early preparation; identification of a local transition coordinator or facilitator; good communication; the development of individual transition plans; the encouragement of self-management; and follow-up and evaluation.[4]

10. The Commission is not asked by the terms of reference as to whether some particular standard was met by the transition process. Rather it is asked whether the transition arrangements for the transition clients were "adequate". That conveys a focus on what was achieved rather than whether a process was textbook. It also makes it clear that it is not whether it was ideal or as desired. By "adequate" it means "sufficient" for the needs of the "client".

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[3] QHD.008.004.9683
[4] QHD.008.004.9683

Who bore the responsibility to ensure transition arrangements were adequate?

11. WMHHS, with oversight from its Board, was responsible for transitioning arrangements and the CHQ was responsible for developing new services and ensuring continuity of services for BAC patients.

Transition from the BAC

12. Dr Brennan was phoned on 10 September 2013 by Dr Peter Steer and asked to take over the clinical care of inpatients and day patients at BAC as of the following day and act as clinical director of the unit in the transition process.

13. Dr Brennan walked into a situation where: Dr Sadler had been suspended; she was not given a "handover" from Dr Sadler; she did not know that she had been engaged to undertake transitioning having been advised that an urgent replacement was required for Dr Sadler and that the BAC was closing; she assumed a transition process had commenced but it had not[5]; people were confused as to when BAC was closing, partly as a result of confusing information about closure being provided by WMHHS; staff morale was low, staff were feeling insecure about their employment, had a heavy workload due to resignations and the lack of skills of casual staff and they were anxious for the future care of their patients; patients were distressed; there was no adequate database or list of services to which patients might transition[6]; education staff at the BAC actively supported the Save the Barrett campaign.

[5] Supplementary statutory declaration of Dr Brennan paragraph [6].
[6] Supplementary statutory declaration of Dr Brennan paragraph [19].

14. These matters made the transition process more difficult but they did not detrimentally affect the transition planning.[7]

15. When Dr Brennan commenced she set about getting to know the patients, finding out about services available that might be suitable[8] and putting together multidisciplinary teams to commence planning for transition. There was plainly considerable work involved both in orientation and settling the patients.

16. Community contact forms were put together for each patient, which Vanessa Clayworth helped to prepare, detailing vocational needs, educational needs, general life skills, money management, meal preparation capacity, hygiene, leisure and recreational activities, access to transport, accommodation, financial support, medical and mental health services, family support for the young person and preparation of service handover documents. [T20-19 lines 1-24]

17. Services that were contacted and considered included private psychiatric, psychology and other medical providers, local CYMHS networks, NGO services, Headspace, community care units, accommodation providers, family homes to the extent that it was a possibility, and acute inpatients units. [T20-19 lines 31-45]

18. Dr Brennan was also aware that there were other new replacement services being developed that were not going to be ready for the Barrett cohort. [T20-21 lines 1-3]

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[7] Supplementary statutory declaration of Dr Brenan paragraph [32(b)(i)]; and Kotze report.
[8] T20-18 lines 31-41.

19. It was agreed between Dr Brennan and Dr Elizabeth Hoehn that Dr Hoehn would engage with SWAETRI in respect of new services so that Dr Brennan could focus on what was currently available for the BAC cohort.[9]

20. Dr Brennan:

(a) held case conferences in order to determine if each patient was emotionally and psychologically ready to consider transition options (Statutory Declaration of Dr Brennan paragraph [35]);

(b) appointed clinical care transitional panels which she headed – each panel consisted of different people (BAC staff and non BAC professionals) depending on the patient's needs (Statutory Declaration of Dr Brennan paragraph [34]);

(c) consulted with service agencies and relevant stakeholders (Statutory Declaration of Dr Brennan paragraph [85]);

(d) consulted with alternative service and care providers (Statutory Declaration of Dr Brennan paragraph [86]);

(e) consulted at length with transition clients and their families and carers (Statutory Declaration of Dr Brennan paragraphs [87] [48]);

(f) consulted with staff at BAC (Statutory Declaration of Dr Brennan paragraph [90]);

(g) contacted patients on the waiting list for BAC to ensure they (or their health provider) knew that BAC was closing and to ensure they had advice about

[9] T20-21 lines 11-15.

alternate services (Statutory Declaration of Dr Brennan paragraph [164] and Exhibit AB11);

(h) considered which new facilities or services were available and whether the patients met the criteria for accessing those services (Statutory Declaration of Dr Brennan paragraph [36]);

(i) asked education staff to write up individual education plans for each young person (Statutory Declaration of Dr Brennan paragraph [49]);

(j) asked CCs to complete questionnaires about patients' aspirations and to establish weekly contact with parents (Statutory Declaration of Dr Brennan paragraph [50]);

(k) developed a transitional care plan for each individual patient with reference to their previous involvement with services and therapists in order to identify services that were developmentally appropriate and accessible both physically and financially, while providing good quality care addressing any risk of harm (Statutory Declaration of Dr Brennan paragraph [45]);

(l) in addition to looking at health care providers, identified broader community supports and accommodation providers using community service data bases, yellow pages, and NGOs and holding stakeholder meetings with such bodies (Statutory Declaration of Dr Brennan paragraphs [52], [53] [54]);

(m) met with individual agencies after the stakeholder meetings including the Department of Child Safety, Personal Helpers and Mentors Service, MNHHS, MSHHS, Transitional Housing Team and Logan Adolescent Unit (Statutory Declaration of Dr Brennan paragraph [55]);

(n) phoned and emailed numerous services and practitioners (Statutory Declaration of Dr Brennan paragraph [56]);

(o) had site visits (Statutory Declaration of Dr Brennan paragraph [57]);

(p) escorted young people on site visits (Statutory Declaration of Dr Brennan paragraph [58]);

(q) assessed quality of services and dismissed from consideration services that were unsuitable for particular patients (eg a residential service at Greenslopes operated by Aftercare) (Statutory Declaration of Dr Brennan paragraph [63]);

(r) with the panels, explored care options, developed a list of possible options, communicated with receiving services details of the patient's history, maintained contact with young persons and their families and service provider to monitor progress as transitions commenced (Statutory Declaration of Dr Brennan paragraph [40]);

(s) held case conferences weekly where, when appropriate transitional plans were discussed (Statutory Declaration of Dr Brennan paragraph [51]);

(t) kept WMHHS updated as to progress of transition plans and transition care. (Statutory Declaration of Dr Brennan paragraph [40(e)]);

(u) with the transition panels, convened and attended meeting with and to identify care options and then to facilitate transition of young people to services. (Statutory Declaration of Dr Brennan paragraph [42]);

(v) visited twice, (Statutory Declaration of Dr Brennan paragraph [65]);

(w) visited [redacted] at [redacted] and educated the team there about [redacted] and the level of risk (Statutory Declaration of Dr Brennan paragraph [69]);

(x) was aware that Vanessa Clayworth also visited [redacted], and identified risks in writing and orally (Statutory Declaration of Dr Brennan paragraph [69]);

(y) was aware that while BAC was operational staff were in constant contact with receiving services (Statutory Declaration of Dr Brennan paragraph [154]);

(z) was aware that for the first few days after transfer to [redacted] was visited by BAC nursing staff who initially shared shifts with [redacted] staff (Statutory Declaration of Dr Brennan paragraph [155]);

(aa) was aware that [redacted] was visited by BAC nursing staff and [redacted] therapist during the first week after transfer (Statutory Declaration of Dr Brennan paragraph [156]);

(bb) was aware that risk management and risk assessments were conveyed orally and in writing to all services where young people were to reside (Statutory Declaration of Dr Brennan paragraph [71]) and that these risk assessments were updated weekly in case conferences (Statutory Declaration of Dr Brennan paragraph [72]);

(cc) initiated a phone review on 29 January 2014 of each young person, de-identified the information and communicated it to the executive (Statutory Declaration of Dr Brennan paragraph [64] [159] and Exhibit AB-5);

(dd) conducted another phone review on 3 March 2014 and produced another document emailed to the executive intended to highlight to WMHHS any

emerging issues (Statutory Declaration of Dr Brennan paragraphs [73] [160] and Exhibit AB7).

21. The transition process undertaken by Dr Brennan was an individualised, patient-centred process involving the patients, their families and their carers. The most appropriate receiving services available for each patient were carefully chosen. Follow up and evaluation took place.

22. The process did not meet key principles in some areas that were out of Dr Brennan's control.

23. For example, the process was not underpinned by formal guidelines. There were none. There is a guideline now. The process did not always involve good, clear communication but this was the role of the WMHHS, in particular, Ms Kelly and Ms Dwyer. The process was conducted in a stressful environment because it was not a true "transition" for the BAC patients. It was a transfer from a centre that was closing by January 2014 and the communication around that closure tended to create confusion and mistrust.

Who were the transition clients?

24. Counsel Assisting have indicated the 16 clients who, in their view, potentially fall within the definition of "transition clients".

25. In order to be a "transition client" under the terms of reference the patient had to have been "*transitioned*" to alternative care arrangements "*in association with the closure or anticipated closure*" of the BAC, whether before or after the closure announcement.

[redacted][10] was transferred out of the BAC, not in association with the closure of the BAC, but for clinical reasons to an acute unit. [redacted] departure from the BAC was ultimately not a "transition" but a transfer for clinical reasons to another service.

26. Counsel Assisting, in their closing submissions, have focussed particularly on 4 of the patients, all of whom required long-term accommodation and who, it was submitted, were affected by the impending closure of the BAC and a lack of time: [redacted]. Submissions are made below in relation to those patients. It is assumed in the absence of any submission from Counsel Assisting, and bearing in mind especially the limits of what Dr Brennan was cross-examined about, that no other individual patient need be addressed as no issues arise with respect to them.

What are the circumstances of each transition client's transition arrangements?

[redacted]

27. [redacted]

[10] T20-60 lines 20-37.

28. Professor Kotze and Ms Skippen reviewed transition arrangements made for as part of their investigation.[12]

29.

30.

[11] Statutory Declaration of Dr Brennan page 35.
[12] Exhibit F to the affidavit of Professor Kotze page 180.

31. [redacted]

32. Further in cross-examination of Dr Brennan it was said:

[redacted]

[13] Second Supplementary Statutory Declaration of Dr Brennan DAB.005.0001.0033 paragraph 95.
[14] See Statement of Vanessa Clayworth WMS.9000.0018.00001 at .00012 paragraph 15.25.

[redacted]

33. [redacted]

34. [redacted]

[15] Evidence of Ron Simpson T21-109 lines 24-29.

35.

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37.

[16] Statutory Declaration of Dr Brennan page 32.
[17] Exhibit F to the Affidavit of Professor Kotze page 174.

38.

39.

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41.

[18] Statement of Dr Ian Williams 9 March 2016 MNH.900.0005.0001 paragraph 8.
[19] Further Statutory Declaration of Dr Brennan page 28.

[redacted]

[redacted]

42. [redacted]

[20] Dr Brennan's email of 18 December 2013 DAB.004.001.5610
[21] Affidavit of Dr Brennan page 30.

43. [redacted]

44. [redacted]

45. [redacted]

46. The submission in particular at paragraph 570 can only be described as surprising. The tone of it is not in keeping with other submissions made about Dr Brennan. The submission was not supported by a question put to Dr Brennan that she was putting "spin" on her evidence or that any aspect of her evidence was "disingenuous". It does not appear that any new fact has since come to the Commission's attention which explains that failure.

47. [redacted]

[22] Exhibit F to the affidavit of Professor Kotze page 181.
[23] T23-46 lines 12-14.

48. The submissions concerning Dr Brennan's evidence in this regard have not noted the significance of the evidence of Emma Hart QHD900.006.0001 or Felicity Curtis QHD900.005.0001, the nurse unit manager and the CNC at the Acute Unit in or the evidence of Dr Tovey QHD900.008.0001, the treating psychiatrist, as supporting Dr Brennan's evidence. Rather, that evidence is noted in isolation from it.

49. That evidence supports what Dr Brennan had said, that is that whilst it remained the case that there was a lack of relevant services available in did not need them. condition had improved, as it has been improving prior to discharge from BAC.

50. has offered evidence that is contrary to Dr Brennan's evidence and indeed contrary to the evidence of the three aforementioned witnesses. Following the cross examination of Dr Brennan, with the absence of any challenge to her in cross examination to suggest that some particular adverse submission might be made against her (as the pejorative submissions in paragraph 570 plainly do), Senior Counsel for Dr Brennan informed the Commission that it was not intended to cross- examine witnesses on topics which Dr Brennan had not been cross-examined about [T21-30.25]. That reflected an understanding that adverse submissions would not be advances on topics not the subject of cross-examination.

51. evidence needs to be treated with considerable care.

52. [redacted]

53. [redacted]

54. [redacted]

55. The submission in paragraph 570 cannot be sustained.

56. Aside from the matters mentioned above, it is also illogical. To state that the patient had progressed to the point where did not require supported accommodation in is not putting a "positive spin" – it is telling the truth. The submission provides no justification for the slur that it makes. Nor does it do so with respect to the claim about Dr Brennan being "disingenuous". There is nothing disingenuous in saying that the patient did not require supported accommodation in when she did It is again simply telling the truth.

57. As for the submission at paragraph 581, whilst Dr Brennan acknowledged that good progress was surprising, that with respect says far more about the quality of care that had received in the latter part of stay at the BAC as well as the quality of care seemingly received at the . In particular, as Dr Brennan had explained, the transition process itself seemed to be a significant event for adjusting to the idea that could in fact exist outside of the BAC (see Counsel Assisting submission paragraph 574).

58. Dr Brennan's note of progress concerning was then doing very well and plainly from its content as well as the notes made at .0081 drew on information provided by

59. It should be found by the Commission that transition was indeed adequate, and not begrudgingly so.

60.

[24] DAB.001.0001.001 at.0079

61. [redacted]

62. [redacted]

Were the transition arrangements adequate?

63. Associate Professor Kotze and Tania Skippen in their report reached the conclusion that all transitions were adequate. They found that "*whilst the general atmosphere of crisis contributed to the complexity of the situation, it does not appear to have detrimentally affected the process of transitional care planning for the patients.*"

[25] Statutory Declaration of Dr Brennan page 29.
[26] Exhibit F to the affidavit of Professor Kotze page 176.
[27] Further Statutory Declaration of Dr Brennan paragraph 30.

64. Professor Kotze was called as a witness, not as an expert witness per se, but rather as an expert who, as a matter of historical fact, performed a review of the transition arrangements and expressed a view plainly supportive of Dr Brennan. The opinion Professor Kotze expressed was tested with respect to what she had and had not taken into account, though variant hypotheses of facts that might have impacted upon her opinion were not explored or intended to be explored, by the consent of those parties interested. In these circumstances her opinions can be taken into account though they do not have the same weight of themselves that they might have had, had her evidence been open to more elaborate cross-examination. That said, there is no properly informed expert opinion that is critical of the transition arrangements and the more extensive evidence before the Commission of what did in fact occur is strongly supportive of the same conclusions that Professor Kotze and Ms Skippen drew. In those circumstances, the Commission should reach the same conclusions itself.

65. The Commission should also note that Professor Kotze and Ms Skippen plainly did know about parent complaints and issues and were able to at least examine the paperwork evidencing those complaints and how they were dealt with. There is no reason to think that information from the school staff would have meaningfully informed the conclusion to be reached.

66. It is also apparent that the reviewers took into account experiences at the receiving services insofar as they informed the question of the suitability of the selection of those receiving services.

Adequacy of care support and services to the families of transition clients

67. Terms of Reference 3(e) requires that the Commission consider the adequacy of the care support and services that were provided to transition clients and their families.

68. That term of reference should be construed as being confined to families only insofar as it relates to appropriate and necessary care, support and services from the viewpoint of the adolescent. When it was put to Dr Brennan in cross-examination by Counsel Assisting that she was required to identify services that provided or touched upon family support, Dr Brennan replied: "*Support of the family for the young person, not necessarily supporting the family independently.*" [T20-19 lines 21-22]

69. Hospitals and health services have a legal relationship along with the necessary and relevant consent to providing treatment to patients. They do not have the same relationship or consent to provide care and support to families more generally. The terms of reference cannot be taken to mean that the hospital and health service or the BAC or Dr Brennan owed some positive duty to provide care, support and services to the families of the transition clients. The terms of reference must be read that any care support and service provided to the families of transition clients was to be provided only insofar as it related to the care support and services offered to the adolescent. Were it otherwise, there would not be any limit to the care, support and services for families (and indeed who that term is to be taken to include).

70. The submission of Counsel Assisting at paragraph 711 is challenged, in part. Communication and consultation with families by clinical staff and in particular Dr Brennan, Ms Clayworth, Ms Hayes and Ms Hughes was extensive. No challenge was made to the evidence of these witnesses by a suggestion they should have done more. Subjective complaints otherwise need to be scrutinised against objective evidence. At paragraph 695 of the submission [redacted] evidence is cited. Aside from the insightlessness of her proposition that [redacted] might be transitioned home, Dr Brennan explained, in unchallenged evidence, that her face to face meeting with [redacted] was

in November (before the transition plan was formed) and that a scheduled meeting for the purpose of giving information to [redacted] on 16 December was not attended by [redacted][28] Similarly, the contemporaneous document exhibited at .0056 to Dr Brennan's third statement reflects [redacted] lack of engagement with communication about transition when offered.

71. [redacted]

72. Parents made anxious about their children's care by the closure, the [redacted] of Dr Sadler and a variety of other matters may have an opinion about the adequacy of communication but absent some concrete instances being identified, there cannot be a finding based on "the vibe" of general complaints made generally by families. An observation that parents were not given copies of documents containing transition plans is petty without recognising that they were told of the plans (or offered to be told) and where it was not common practice for a copy of such a document to be given to parents of patients.

73. Furthermore, these submissions invite findings to be made critical of, relevantly, amongst others, these clinical staff concerning an absence or inadequacy of communication by them when, in the face of their evidence about extensive communication, they were not challenged. Reference is made again to what was said by Senior Counsel for Dr Brennan at T21-30.25 about not cross-examining witnesses on matters that were not put in issue by cross-examination of Dr Brennan. The point is more so reinforced here by the absence of any issue of communication or lack thereof

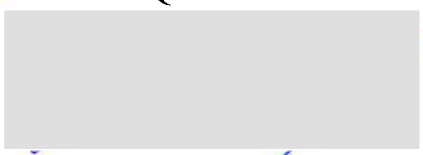
[28] DAB.005.0001.0001 at .0021 paragraph 61.
[29] Dr Brennan's second supplementary statutory declaration DAB.005.0001.0001 at .0017 paragraphs 43-46.

identified in the Commission's "Potential Transition Client List" document. That document was expressly intended to identify to the parties the issues to be pursued and was expressly relied upon by Dr Brennan (as identified by that transcript reference) in the choices as to which witnesses to cross-examine and on what topics. The approach now made is both factually wrong and procedurally unfair.

CONCLUSION

74. There ought be no adverse findings in relation Dr Brennan, Ms Clayworth, Ms Hayes and Ms Hughes in particular, together with the others who contributed to the transition planning, who acted at all times with the best possible care of the young people at the forefront of their minds. Moreover, the quality of the care and the effort put into providing it, in a highly charged and indeed at times hostile environment, whilst being undermined and smeared by some, in what would ordinarily be a difficult job in any case, in fact warrants commendation in the Commission's findings.

GW Diehm QC



CJ Conway
Counsel for Dr Anne Brennan
23 March 2016