14.4 For those reasons, planning commenced with a target of transitioning patients around the December 2013/January 2014 Christmas school vacation period, unless patients were discharged prior to this date.

14.5 Neither early 2014, nor any other date, was ever considered "the best deadline" for the closure of BAC, as no deadline for the closure was ever established or imposed.

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

14.6 There was never a determined closure date, rather closure of BAC was determined by the clinical transition of patients. Once all patients were clinically transitioned, BAC was closed.

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

14.7 I did not formally consult as to a date for closure however the Chief Executive and I formed a view that the desirability of transition of patients occurring over a Christmas school vacation period meant that the December 2013/January 2014 Christmas school vacation period was the obvious period to target for transition.

14.8 I did discuss potential time frames with Mr Peter Blatch, and he was comfortable with the chosen time frames as they related to the Barrett School.

14.9 I received affirmation of the choice of a Christmas 2013/14 when, in the course of the telephone calls to parents and carers on 6 August 2013 to advise them of the Minister's announcement, Dr Sadler spoke to each about the individual circumstances of their adolescent and generally the theme he expressed was that many would be on a discharge trajectory which was within that timeframe in any event, either based on their clinical path or their age.

14.10 A transition team (discussed below) was established to plan the transition of each patient individually. I was guided at all times by the transition team, most particularly Dr Anne Brennan who was the Acting Clinical Director BAC during the transition period and who headed the transition team.

14.11 Throughout the transition period a BAC Weekly Update Meeting was held, chaired by me. At those meetings, Dr Brennan gave weekly feedback as to the transition process and issues arising with individual transfer arrangements.

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

14.12 Dr Brennan, Dr Stedman, Dr Geppert and others provided feedback over the transition period as to progress with transition and the likely timing for completion of transition. Their advice regarding transitions, and in particular Dr Brennan's clinical opinion regarding the patient's transitions was the sole criterion determining the timing of BAC closure.

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

14.13 A closure date of early (January) 2014 was never set, and accordingly there was no need for any "review mechanism" to review that date.

14.14 Rather, the Christmas 2013/14 period was a target for completion of transition of patients, but this was entirely flexible. The timing of closure of BAC was dictated entirely by the issue of safe and appropriate transition of patients to other services.

14.15 Staffing was available to continue care as needed if BAC had remained open into 2014 due to clinical needs of any patient.

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

14.16 In relation to staff:

(a) On the announcement of closure I met with all the available BAC staff on the afternoon to provide them with early advice regarding the closure. I followed this with an all of staff email outlining the decision and potential for early 2014 closure. Attached and marked **SK-17** is a copy of that email.

(b) On Thursday 3 October 2013 I met with BAC staff to advise staff that we were working towards the end of January 2014, noting this was flexible and responsive to the needs of the individual patients. Subsequently this was followed up through a staff communiqué. That communiqué is within the bundle annexed at **SK-29**.

14.17 In relation to parents and carers:

(a) I endorsed and provided ongoing Fast Fact sheets to families that outlined the proposal for new service models and transition to be completed by early 2014. These were also posted on the WMHHS website.

(b) The Fast Facts sheet in October 2013 identified we were working towards an end of January 2014 closure, noting flexibility. Attached and marked **SK-18** is a copy of the Fast Facts sheet.

14.18 The Executive Director MHAODB and the Queensland Commissioner for Mental Health were advised on 3 October 2013 of the planned focus on end January 2014 date.

14.19 On 22 October 2013 I wrote to all Executive Directors and Clinical Directors of Mental Health across the State advising them of progression and closure plans and advising that no new patients would be accepted into BAC. Attached and marked **SK-19** is a copy of that memorandum.

15 In the event Ms Kelly did not have any personal 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 Ms Kelly become aware of the decision that the closure date would be early (January) 2014;

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

(c) the extent to which Ms Kelly was aware of the existence of any flexibility with respect to the closure date or any review mechanisms?

15.1 Not applicable.

16 Did Ms Kelly consider the early 2014 closure date to be appropriate and the reasons as to why/why not?

16.1 I supported that the Christmas school vacation period 2013/14 was an appropriate and least disruptive time of year to transition patients because:

(a) It was necessary to provide certainty to patients and their families as to the future arrangements for patients. A more lengthy period leading up to closure would have potentially increased the anxiety for patients and their families.

(b) As time progressed , patients with less complex care needs were discharged or were transitioned, in particular once the school year finished. This left a small number of complex needs patients in a large, unsuitable building acutely aware of the loss of their cohort and the changes to their future placement. I was advised that this was not therapeutically beneficial for those patients in the long term and that in some cases it would result in an escalating risk of self harm for those patients, therefore finalising the transition of those patients was in their best therapeutic interests.

(c) Once closure of BAC had been announced, some staff commenced looking for employment elsewhere. I appreciated that the potential for staff issues to be disruptive to service delivery at BAC would increase the longer the period prior to closure because:

(i) With the inevitable departure of staff who found employment elsewhere, there would be a loss of continuity of staffing which had the potential to affect patients.

(ii) For those staff who did not immediately look for other employment, uncertainty regarding their employment future had the potential to cause deteriorating staff morale which was not conducive to a productive clinical environment for patients nor was it beneficial to staff.

17 Did Ms Kelly 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?

17.1 On 9 November 2012, after Dr Brett McDermott had made a public comment to the effect that BAC would be closed, Chief Executive Lesley Dwyer and I met with BAC staff

and Barrett School staff to advise them no decision had been made around service delivery and that WMHHS would be convening an expert clinical reference group to advise regarding service delivery options.

17.2 Between then and when BAC actually closed I had extensive meetings with staff around closure issues.

17.3 On 14 December 2012, I attended a meeting between the Health Service Chief Executive, Lesley Dwyer, WMHHB Chair, Mary Corbett and the then Minister for Health, Lawrence Springborg. Attached and marked **SK-20** is a copy of the speaking notes for Ms Corbett for that meeting.

17.4 I met with the QNU in August 2013 and November 2013 to discuss workforce redeployment.

17.5 On 17 June 2013 I attended a meeting with the Director-General of Health together with Lesley Dwyer and Dr Leanne Geppert to discuss next steps following the WMHHB decision to accept the recommendation to close BAC.

17.6 On 2 August 2013, Lesley Dwyer and I met with the Deputy Director-General of the Department of Education. There were other representatives of the Department of Education also present. The meeting was to discuss the closure of BAC and the logistics of closing the Barrett School on the BAC site.

17.7 On 30 September 2013 Mary Corbett, Lesley Dwyer and I met with the Queensland Mental Health Commissioner to discuss her role generally, and the closure of BAC was included in that discussion.

17.8 I had ongoing discussions with MHAODB regarding closure of BAC.

17.9 From the time the Minister for Health announced closure of BAC in August 2013, I attended many meetings regarding transition of patients. In particular, once Dr Anne Brennan was appointed as Acting Clinical Director BAC and tasked with heading the transition team, I commenced a BAC Weekly Update Meeting, at which Dr Brennan would provide a briefing as to progress towards clinical transition of patients. It was this process which dictated the closure date for BAC.

Transition arrangements

18 What processes were put into place, and by whom and when, to communicate the closure of BAC to parents of BAC patients and BAC staff? In particular:

(a) Was any governance model put in place by the West Moreton Hospital and Health Service to manage the oversight of the transition and, if so, what did it involve?

18.1 The transition of individual patients was a clinical process and led by the Acting Clinical Director BAC Dr Anne Brennan.

18.2 Dr Brennan had a small clinical team and provided a regular weekly update to myself through the BAC Weekly Update Meeting.

18.3 I provided regular update and oversight to the Health Service Chief Executive, Lesley Dwyer.

18.4 Monthly updates regarding de-identified cases and issues as well as a progress report were provided to the State-wide Adolescent Mental Health Extended Treatment Initiative.

18.5 An Issues Register was kept to ensure all issues were identified and actioned. Attached and marked **SK-21** is a copy of the Issues Register as at 22 January 2014.

(b) Who was responsible for the arrangements for the transition of patients of the BAC once the decision to close the BAC had been made? What was the extent of Ms Kelly's involvement/responsibilities?

18.6 The need for clear transition care pathways to support discharge was identified and a decision was made to establish care panels.

18.7 To the best of my recollection, Dr Geppert identified the need to have a team to be responsible for planning and implementing each individual transition. A transition team was established which was responsible for the clinical arrangements for the transition of patients.

18.8 The transition team comprised:

(a) Dr Anne Brennan, Acting Clinical Director BAC;

(b) Vanessa Clayworth, Acting Clinical Nurse Consultant (CNC), BAC;

(c) Laura Johnson, Project Manager – secretariat ;

(d) for each particular patient, the case co-ordinator for that patient and other key clinical stakeholders.

18.9 Dr Elisabeth Hoehn , Consultant Child Psychiatrist, Children's Health Services acted as a clinical mentor for Dr Brennan.

18.10 Sue Daniel was also initially a part of the transition team in the role of liaison with families. However Ms Daniel went on sick leave shortly after the transition process commenced and did not return.

18.11 I was not a member of the transition team nor was I involved in the day-to-day management of transition arrangements for patients.

18.12 I convened a BAC Weekly Update Meeting which was attended by:

(a) Myself;

(b) Dr Leanne Geppert;

(c) Dr Anne Brennan;

(d) Dr Elizabeth Hoehn;

(e) Mr Will Brennan, Director of Nursing, The Park;

(f) Padraigh McGrath – Nursing Director Secure Services;

(g) Dr Terry Stedman or, in his place Dr Darren Neillie; and

(h) Ms Michelle Giles -Director Allied Health and Community Mental Health.

18.13 Dr Bill Kingswell on behalf of MHAODB also attended the first few meetings, however his involvement ceased early.

18.14 At the BAC Weekly Update Meeting, Dr Brennan advised as to the progress with the transition of patients, and brought to the attention of the meeting any issues or difficulties which she was experiencing, for example any pushback from other agencies with whom she was negotiating transition arrangements. The meeting would discuss ways to overcome any such difficulties and appropriate actions would be determined. Ongoing communication plans were confirmed and other strategic issues identified and addressed.

18.15 The BAC Weekly Update Meetings were held from August 2013 to January 2014. Attached and marked **SK-22** is a bundle of BAC Weekly Update Meeting agendas and minutes.

(c) Did there exist a transition plan (or plans) and/or transition taskforce for the transitioning of patients at BAC and, if so, what did it (or they) involve? (please supply a copy)

18.16 As noted, a transition team was established to manage the transitioning of individual patients.

18.17 A Transition Panel was convened in respect of each patient to consider all aspects of the patient's care, including accommodation needs, clinical needs and education for the patient. The Transition Panel consisted of the members of the transition team together with:

(a) A teacher of the Barrett School.

(b) A representative of the HHS to which it was planned the patient would be transitioned.

18.18 A transition plan was established for each patient. The transition plan was an individual process and the level of complexity of the plan depended upon the complexity and circumstances of the patient.

18.19 A multi-disciplinary Complex Care Review Panel was convened for one patient with high or complex needs. Attached and marked:

(a) **SK-23** is the Terms of Reference for the Panel.

(b) **SK-24** is the Summary of the meeting which details the issues discussed, conclusions drawn, recommendations made and review date.

19 Explain the nature and extent of Ms Kelly's involvement in the transition arrangements for the transition of patients from the BAC (and dates when this occurred), including:

(a) consultation(s) with experts and stakeholders (and when), and the nature of those consultation(s);

19.1 I consulted with Dr Anne Brennan on a weekly basis at the BAC Weekly Update Meeting regarding the progress of transition of individual patients.

(b) **consultation(s) with alternative services/care providers for patients of the BAC (and when), and the nature of those consultation(s);**

19.2 Generally I was not involved in consultations with alternative services/care providers for patients of BAC as those arrangements were managed by the transition team.

19.3 On two occasions I became involved to a limited extent. Those occasions were:

(a)

(b)

(c) consultation(s) with parents of patients of the BAC (and when), and the nature of those consultation(s);

19.4 When I was advised on 6 August 2015 that the Minister for Health would be announcing the closure of BAC later that day, I met with Dr Sadler and Dr Stedman, and together we telephoned the parent/carer contact for each current BAC patient to advise them that the Minister would be making that announcement and providing them with advice as to what it meant for their adolescent.

19.5 I followed up that telephone contact with an email the following day to each parent/carer contact. Attached and marked **SK-25** is a copy of a pro forma of the email sent and a follow up email to one parent where transmission failed due to a typographical error in the email address.

19.6 I produced a series of Fact Facts sheets which were provided to parents of patients regarding the transition process and matters related to closure of BAC, and which were posted on the Queensland Health website. Attached and marked **SK-26** is a bundle of Fast Facts.

19.7 On or about 30 August 2013 Lesley Dwyer, Dr Stephen Stathis and I met with the [redacted] where they tabled a paper outlining their concerns regarding the closure of BAC. Attached and marked **SK-27** is a copy of that paper

19.8 In early November 2013 Lesley Dwyer received a communication from [redacted] who stated that a number of parent/carer contacts had not been receiving my communications and were unhappy with the information they were receiving. Following that meeting, at Ms Dwyer's request I telephoned each parent/carer contact to discuss the information I had been sending, confirming they had received the material, and asking if there were any issues they wished to discuss. It was identified at that time that [redacted] had not received the information previously. We were able to rectify that immediately.

19.9 I followed up those conversations with a letter to each parent/carer contact. Attached and marked **SK-28** is a bundle of the letters sent.

19.10 There were [redacted] had contacted Lesley Dwyer directly, seeking to discuss transition of their child. At Ms Dwyer's direction, in both cases I had discussions with the carer regarding arrangements for the patient.

(d) consultation(s) with staff working at the BAC (and when), and the nature of those consultation(s);

19.11 I met with all staff available the day the Minister announced the outcomes of the ECRG, and those not present were contacted via phone for an update.

19.12 I convened the BAC Weekly Update Meetings which included relevant staff leading

those working at the BAC in relation to transition arrangements.

19.13 I produced a series of Staff Communiqués providing information to staff regarding the closure of BAC. Annexed and marked **SK-29** is the bundle of Staff Communiqués.

19.14 I visited the BAC unit on an 'unannounced' basis to allow the opportunity for individual discussions with any staff that were on shift.

19.15 I met with staff member union organisers for the Queensland Nurses Union on 20 August 2013 and again on 4 November 2013 to discuss industrial issues associated with the closure.

(e) consultation and/or communication with the Department of Education and Training and staff of the BAC school (and when), and the nature of those consultation(s);

19.16 My initial meeting with staff on 9 November 2012 included members of the teaching team. Following that meeting I felt it would be more appropriate for Education Queensland to communicate with their staff as WMHHS had no line management or operational accountability for the education staff.

19.17 Fast Facts sheets were provide to Peter Blatch for his dissemination to the Education staff.

19.18 I also had communications with him regarding education transition arrangements and the closure of the Barrett School. These communications were mostly by telephone and I do not now recall the dates of those conversations except to say that they would have been in the second half of 2013.

(f) input into decisions made concerning the transition of particular patients from the BAC.

19.19 I was not involved in decisions concerning the transition of particular patients from BAC save that where difficulties were escalated to the BAC Weekly Update Meeting, I had input into the resolution of those issues.

20 Explain the nature of Ms Kelly's involvement/responsibilities with respect to the

provision of information and support to staff of the BAC, including decisions made with respect to their future employment (or otherwise).

20.1 As Executive Director Mental Health and Specialised Services, I had accountability for staff. In that role, I provided advice to staff regarding closure of the BAC including:

(a) When I was advised on 5 August 2013 that the Minister would be announcing the closure of BAC that day (although he did not actually do so until 6 August 2013), I convened a meeting of staff of BAC ahead of the Minister's announcement. That meeting was held at 3pm on 6 August 2013, and I arranged for two senior staff who were present for the meeting to then telephone any staff members who were not present. Attached and marked **SK-30** is a copy of my speaking notes from that meeting.

(b) I issued Staff Communiqués providing regular updates to staff regarding the transition and closure which are annexed as SK-29 above.

20.2 I appointed Lorraine Dowell, Allied Health Team Leader Non Secure Services and Senior Occupational Therapist to focus as a liaison and support for Allied Health staff at BAC. This included individual meetings and support for staff. I requested Will Brennan, as Director of Nursing to provide a similar support for nursing staff at BAC.

20.3 WMHHS Human Resources Services managed the redeployment and redundancy of staff from BAC according to well defined Queensland Health pathways for redeployment and redundancy. That process was led by Kerrie Parkin.

20.4 Employee Assistance Support (**EAS**) was offered to all staff affected by the closure of BAC.

20.5 Voluntary early redundancies (VERs) for BAC staff were handled as part of a State-wide VER process which was in progress at that time. That process was extended beyond the end date for the State-wide process to enable completion of the VERs for BAC staff to ensure our focus was on appropriate transition for the adolescents, not aligned with any particular staffing date imperative.

21 Who was responsible for responding to/addressing any concerns raised during

the transition process, including communicating with patients, parents of patients, staff and stakeholders?

21.1 Patient concerns were addressed by senior clinical and nursing staff members.

21.2 Clinical issues regarding transition were addressed by the Acting Clinical Director BAC, Dr Anne Brennan and her team.

21.3 Communication with parents/carers with respect to clinical matters or the detail of particular transition arrangements was through Dr Brennan and her team. Concerns regarding timing of the closure of BAC and other such matters which were not patient-specific were generally addressed by me or by Dr Geppert.

21.4 A small number of parents, possibly three, communicated concerns directly to the Health Service Chief Executive, Lesley Dwyer. She would either respond directly to the parent or, if a formal response was considered appropriate, I would prepare a draft for her approval and she would send the communication.

21.5 WMHHS also received some communications from members of the public with no personal connection to BAC. WMHHS endeavoured to respond individually to each such communication, although a more pro-forma response was provided to some communications, particularly multiple communications received had the same body of text and as such there was no individual personal issue requiring a response.

22 What arrangements were made for adolescents on the BAC waiting list who would otherwise have been admitted to the BAC, and when were those arrangements made?

22.1 I had no direct involvement in this process.

22.2 Dr Geppert was responsible for this aspect. She has informed that she arranged for a State-wide senior social worker, Kathy Stapley to review the waitlist in partnership with Dr Brennan's team. This involved reviewing the available material concerning each of the adolescents on the BAC waiting list and in each case discussing the patient with the referring provider to ensure that alternative clinical care was in place as required.

23 Were there any arrangements in place to monitor the adequacy of the transition processes for patients of BAC (and their families) and staff of the BAC?

23.1 Transition is a clinical process and as such was handled by the transition team.

23.2 In about early November 2013 Lesley Dwyer was contacted by the mother of one patient, who suggested that some parents/carers were not receiving the fact sheets which I had been emailing to parents. She suggested that there were parents/carers who were unhappy with the level of information being provided.

23.3 For that reason, I personally contacted each parent individually and had a conversation with them in which I asked how they felt the transition process was going and sought feedback as to any issues they were encountering. I took the feedback from those conversations to the transition team. Attached and marked **SK-31** is a copy of a spreadsheet which I created for this purpose.

23.4 In relation to my telephone contacts with parents, the overarching feedback was reasonably good. There were some complaints around follow-up and I ascertained from those conversations that in one case, the transition team had been communicating with one parent but as the parents were estranged, contact should have been made with both so that both parents had the same information. None of the complaints were about the adequacy of clinical care post transition, although it is fair to say that the more complex cases were still at BAC at that time.

23.5 I followed up the telephone calls with a letter to each parent or carer. **Attached** and marked **SK-32** is a bundle of those letters.

23.6 In about February 2014, approximately one month after the completion of all patient transitions, Dr Brennan contacted either the patient, the patient's parent/carer or the service to whom the patient had been referred (as appropriate) for feedback as to whether the transition was working for them.

Dr Sadler

24 Why was Dr Sadler stood down from his position at BAC? Who made that decision and for what reason or reasons?

24.1 The reasons for the standing down of Dr Sadler from his position at BAC are as set out in a letter from Leslie Dwyer to Dr Sadler dated 13 September 2013. Attached and marked this **SK-33** is a copy of that letter.

24.2 The decision to stand Dr Sadler down was made by Ms Dwyer.

24.3 The reasons for Dr Sadler standing down are as set out in **SK-33**.

25 On what date did Ms Kelly first become aware of the matters the subject of the decision to stand down Dr Sadler, and from whom and by what means?

25.1

25.2

25.3

25.4

25.5 [redacted]

25.6 After considering the brief provided to him, Dr Cleary asked whether WMHHS had reported Dr Sadler to the Australian Health Practitioners Regulation Agency (**AHPRA**) in relation to the allegations of lack of governance of the unit. At that stage, WMHHS had not made such a notification. Dr Cleary advised that WMHHS ought make a notification and, if it did not, his office would do so. With Ms Dwyer's approval, I therefore prepared

and submitted the appropriate notification to AHPRA. Attached and marked as **SK-37** is a copy of the notification.

25.7

25.8

Groups

26 Did Ms Kelly have any involvement or input into the formation or work of the 'Expert Clinical Reference Group' (ECRG) with respect to the BAC and, if she did:

(a) who were the members of the ECRG;

26.1 My involvement and input into the formation of the ECRG was that I was Chair of the Planning Group established pursuant to the BAC Strategy Project Plan. The Planning Group:

(a) established the Terms of Reference for the ECRG

(b) invited the individuals to be members of the ECRG.

26.2 I did not have any involvement in the work of the ECRG.

26.3 The members of the ECRG were:

(a) Dr Leanne Geppert (Chair);

(b) Dr Trevor Sadler, Clinical Director BAC;

(c) Dr Michelle Fryer, Faculty of Child and Adolescent Psychiatry;

(d) Dr James Scott, Consultant Psychiatrist Early Psychosis, Metro North Hospital and Health Service;

(e) Dr David Hartman, Clinical Director, Community Youth Mental Health Service (CYMHS), Townsville Hospital and Heath Service;

(f) Professor Philip Hazell, Director, Infant Child and Adolescent Mental Health Services, Sydney and South Western Sydney Local Health Districts;

(g) Ms Josie Sorban, Director of Psychology, CYMHS, Children's Health Qld Hospital and Health Service;

(h) Ms Amanda Tilse, Operational Manager, Alcohol Other Drugs and Campus Mental Health Services, Mater Children's Hospital;

(i) Ms Amelia Callaghan, State Manager Qld NT and WA, Headspace;

(j) Ms Emma Hart, Nurse Unit Manager, Adolescent Inpatient Unit and Day Service, Townsville HHS;

(k) Mr Kevin Rodgers, Principal, Barrett School;

(l) A consumer representative whose name I can provide to the Commission on request; and

(m) A carer representative whose name I can provide to the Commission on request.

(b) what was the expertise of each member, and what was the ECRG's function?

26.4 The expertise of each member of the ECRG is outlined in paragraph 26.3.

26.5 The function of the ECRG is set out in the ECRG Terms of Reference which is annexed **SK-11**.

27 On what date, by what means, and for what purpose, was the ECRG report

provided to Ms Kelly?

27.1 Drafts of the deliberations of the ECRG were tabled by the Chair of the ECRG at regular Planning Group meetings for the benefit of discussion and transparency.

27.2 I received the final ECRG report on or about 8 May 2013 via email from the Chair of the ECRG, Dr Leanne Geppert.

27.3 The purpose for which I received the ECRG report was in my capacity as Chair of the Planning Group.

28 What were Ms Kelly's views in relation to the recommendations contained in the ECRG?

28.1 The Planning Group discussed and debated the content of the ECRG report in a full and frank manner. My views in relation to the recommendations contained in the ECRG report were guided and directed by those discussions.

28.2 As a result of those considerations and deliberations, my views in relation to the recommendations contained in the ECRG were that:

(a) I supported the majority of the recommendations in the ECRG report based on my understanding that they were reflective of contemporary models of care as I understood models of care to be.

(b) I understood Recommendation 2 of the ECRG report to be an attempt to maintain a status quo which did not accord with contemporary models of care. With the exception of Dr Sadler, the other mental health clinicians from whom I had received information (being the MHAODB, Dr Stedman and the mental health clinicians on the Planning Group) expressed the view that the BAC model of care was not contemporary.

(c) The ECRG's statement that not providing a Tier 3 service carried a risk, was not, of itself, persuasive of anything. Providing services in a mental health environment is always associated with risk. The important issue is whether that risk can be managed. In that regard, Recommendation 3 of the ECRG report specifically contemplated the situation of BAC being closed without an alternative Tier 3 service being online first, and stated that the risks associated with this could be managed effectively.

(d) I was sceptical of Recommendation 5, as I was aware that despite the presence of the Barrett School, a number of BAC patients attended school elsewhere (i.e. were supported by education staff to attend school but not at the Barrett School) and others did not attend any school effectively, including the Barrett School despite it being dedicated to the BAC service. Anecdotally, I was unconvinced that attendance or school achievement were any higher for this cohort of patients by having a dedicated on-site school. I therefore questioned whether co-location of a school with clinical services was really necessary. Recommendation 5a essentially assumed the same model as the Barrett School. In my view, education for patients is important but the issues should have been considered more broadly to encompass whether education really needed to be provided on site or could be adequately provided externally.

29 Who appointed Ms Kelly to the 'Planning Group' (PG), on what date and for what purpose (and provide a copy of any appointment paperwork)?

29.1 I was appointed Chair of the Planning Group by Lesley Dwyer.

29.2 I am unable to recall or to identify the specific date of my appointment, but it would have been within a short period prior to the first meeting of the Planning Group which took place on 21 November 2012.

29.3 My appointment was not the subject of any formal appointment paperwork.

30 In relation to the PG:

(a) what was the function of the PG, what did it involve, and when did it first convene?

30.1 The function of the Planning Group is set out in the BAC Strategy Project Plan, which is annexed at **SK-10**.

30.2 The Planning Group first convened on 21 November 2012.

(b) what was Ms Kelly's role and responsibilities as a member of the PG;

30.3 I was the Chair of the Planning Group as well as a member.

30.4 As Chair, my role and responsibilities included the following:

(a) I chaired meetings of the Planning Group.