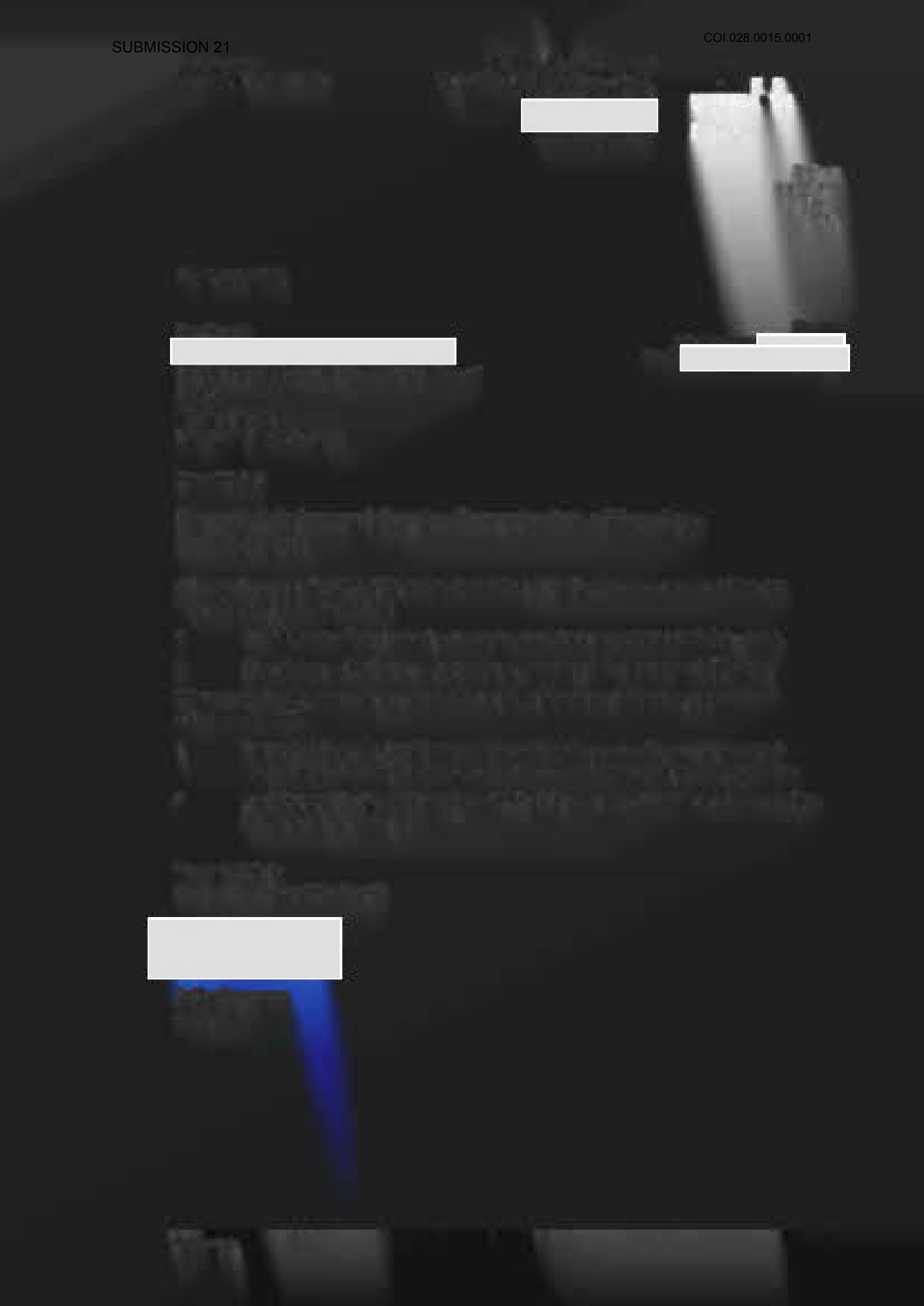

Barrett Adolescent Centre Commission of Inquiry

Submissions on behalf of the West Moreton Hospital and Health Service and the West Moreton Hospital and Health Board

Part 1 – Terms of Reference 3(a) – 3(c)

Contents

1 Introduction

"Mental illness affects 14.4.5 of 12-17 year olds had at least one mental health disorder in the previous 12 months, with a co-morbidity common across conditions ."[1]

Mental illness in childhood and adolescence can have a significant and long-lasting impact on a young person's developmental pathways into adulthood and in some cases across generations. From the age of approximately 12 until the early to mid-20s, a critical period of brain development helps shape future physiological responses as well as patterns of thoughts, feelings and behaviour. Besides physical and sexual maturation, normal adolescent experiences include movement toward social and economic independence, the formation of identity, the capacity for abstract reasoning and acquisition of skills needed to carry out adult relationships and roles. Without appropriate and timely intervention, mental illness may interrupt these experiences and therefore place a young person at greater risk of a wide range of adverse biopsychosocial outcomes. These included poor physical health, impaired social relationships, lower well-being, impaired functioning and greater adversity, including well into adulthood (Chen et al., 2006). Young people experiencing mental health problems may also engage in risky behaviour such as non-suicidal self-injury and/or suicide attempts/contemplation. A 'downward developmental trend' has been noted, such that disorders appear to be starting at younger ages (Zubrick, Silburn, Barton & Blair, 2000). Anecdotally, there has also been increasing complexity and acuity of mental health problems noted over time."

1.1 The pervasive nature of these conditions and the consequences for patients and their families, have been highlighted in the evidence before the Inquiry. Not unnaturally, the place the Barrett Adolescent Centre (BAC) has occupied for them (and some of the staff), has been spoken of in emotive and at times almost evangelical terms.

2 Findings the Commission should make

2.1 It is submitted that the Commissioner ought to make findings as follows:

(a) That the reasons for closure of the Barrett Centre can be categorised as follows:

(i) BAC had never had a formal model of care.

(ii) There had been multiple reviews critical of the operation and governance of BAC (2003 review, 2009 review) in relation to which there had been little effective response.

(iii) There was no clear evidence base for BAC's efficacy.

(iv) It did not align with contemporary thinking, which emphasises care in the community, close to home in order to maximise access to family, peer and other supports likely to contribute to the adolescent's prospects of recovery and continued integration in and engagement with their community of origin.

(b) That the WMHHB was entitled to make the recommendations for closure of the BAC based on the information briefed to it.

[1] Discussion paper p9 citing Lawrence et al 2015. That survey only included anxiety disorders , major depressive disorder, attention-deficit hyperactivity disorder ADHD and conduct disorder. It underestimated the full extent of youth mental illness as it did not include conditions such as PTSD, eating disorders or psychosis.

(c) That the WMHHB did not have, pursuant to the Hospital and Health Boards Act 2011 or the Service Agreement, unilateral power to close the BAC nor did it purport to do so.

(d) That the transitions of the former BAC patients were adequate to meet the needs of their patients and their families.

(e) The transition plans were appropriate and took into consideration patient care, patient safety and service quality.

2.2 In positing four fundamental issues, each of which incorporate an assumption that a BAC is necessary, the analysis of Counsel Assisting has proceeded on a flawed basis which:

(a) is incorrect on a proper evaluation of the weight of the evidence,

(b) has diverted attention from the dissection of the terms of reference in an orderly manner;

(c) the evaluation of evidence has proceeded through that prism; and

(d) if adopted would cause the Commission to fall into error

and should be accorded little weight.

2.3 Despite Counsel Assisting enjoining against 'viewing the issues and the evidence through a pro-Barrett' or 'anti-Barrett' prism', their analysis of expert and other evidence has fallen into the same categorisation of pro and contra evidence for BAC. The excerpts of evidence are selective and arguably further a narrative, itself the subject of comment and objection during the evidence.

2.4 It reinforces Barrett as geographically and systemically isolated and ignores its place within the systemic development, nationally and Statewide, of mental health care for young people. Nowhere does one find any proportionality acknowledged. Starkly, no mention is made that of the 50 or so families contacted only a handful gave statements (or at least statements that were tendered) from, which one might infer that the majority had no criticism of the ilk in those statements.

2.5 In the time limited by the Commission, there is an attempt to respond to the submissions, of some 224 pages in length with an annexed table, hampered by both the size and content of them. If a specific paragraph is not responded to it should not be taken as an acknowledgement of the accuracy or assessment of relevant evidence.

3 Executive Summary

3.1 The aim of BAC at its establishment, when significant stigma was associated with being a mental health patient, was for adolescents to have a place to be managed in a supportive environment [Dr Breakey, 6-36.20-25], see others cope, so that they lost the sense of being abnormal, of being isolated and they could learn from staff and each other [Dr Breakey, CA 6-37.5-15].

3.2 At that time there were no alternative services for child and adolescent mental health, with the first inpatient unit known as CAFTU at the Royal Children's Hospital opening in the 1980s. Outreach services post-dated this.

3.3 At the outset, the aim of BAC was to return the young people back to normal life as much as possible [Dr Breakey, CA 6-37.27 -30]. By the later years, however, the average length of stay had increased from 4 months to 10 months.

3.4 From at least 2004, Professor McDermott opined, that there had been:

> "*some really interesting changes that move us away from long term residential care and the problem that I see in that to things which are more contemporary and more again, ……social ecology- that are more consistent with normal adolescent development." [Prof McDermott XNCA 7-52.34-38],* and avoiding longer stays with associated risks of institutionalisation (and the associated risk of taking up idiosyncratic behaviours and elements of that environment [Prof McDermott XN McMillan 7-61.1-8] eg. regressed behaviour, self harm and disruptive behaviour) [Prof McDermott XN McMillan QC 7-61.12-20].

3.5 The *Queensland Plan for Mental Health 2007 – 2017* (**QPMH**) made provision for the evolution of a new extended treatment adolescent mental health service. One of the leaders of the group that developed that plan was Dr Groves [Dr Groves XNCA 7-76.37-38]. He was requested by the Director-General of Health in 2006 to prepare a plan for mental health and to that end established expert groups. One group looked at child and adolescent issues [Dr Groves XNCA 7-77.7-17]. and formulated a Child and Youth Mental Health Plan, which in turn informed the 2007 to 2017 plan .[Dr Groves XNCA 7-77.26-28]. There was no inclusion of BAC in that plan.

3.6 Thinking at that time was that the treatment of severe mental illness in adolescents needed to be a Statewide service at one location, but reform was needed in the form of improved linking-in to all child and youth services that might be needed for a person once they leave an extended inpatient service and a different approach to in patient care.

> "*Such services needed to be more consistent with the direction which we were heading, which was, a shorter length of stay to try and mitigate institutionalisation effects from long lengths of stay" [Dr Groves XNCA 7-78.28-35*]

3.7 It was known and understood that once this service was commissioned, BAC would be closed.

3.8 The new service was never intended to be a 'relocated BAC' [Dr Geppert XNCA 10-8.32-35]. It was intended to be developed as a contemporary model of care for adolescents requiring extended treatment and rehabilitation. The intention was to review and where opportunity arose, revise and improve upon so that, in fact, it was intended to be a new model of service [Dr Geppert XNCA 10-8.33-34]. Those involved in the development of the model included: Dr Scott, Judy Krause, Dr Sadler, Dr Penny Brassey (Clinical Director CYMHS Townsville), Fiona Cameron (Statewide Principal Project Officer CYMHS), Erica Lee (Manager CYMHS Mater), Prof McDermott, and Dr Michael Daubney [Dr Scott, XN McMillan QC 8-14.36 to 8-15.5].

3.9 The QPMH also provided for the redevelopment of The Park to provide an adult forensic and secure patients only facility. It included a new secure inpatient service, the Extended Forensic Treatment Rehabilitation Unit (EFTRU) and other adult mental health services [Ms Kelly XNCA 11-3.37-39], the capital projects for which were also detailed in the QPMH.

4 Chronology

Date	Event	Delium Reference
1983	Commencement of BAC	
1983 through 1989	Dr Breakey is Medical Director of BAC	
1989 through 2013	Dr Sadler is Medical Director of BAC	
25 February 2008	Queensland Cabinet endorses Queensland Plan for Mental Health 2007 – 17	DPC.003.001.0643

Date	Event	Delium Reference
October 2008	Site evaluation sub-group report (recommends Redlands as preferred option for BAC redevelopment)	MSS.001.002.2229
Late October/early November 2008	Recommendation of site evaluation sub-group accepted by Dr Groves (Senior Director of the Mental Health Branch and also by representatives of Metro South area into which the new service would be going) and by WMHHS.	
11 March 2009	Redlands' site acquired at Cleveland (adjacent to Redlands Hospital)	WMS.6006.0002.54301
20 August 2009 through February 2012	Professor Crompton's Facility Project Team meets over a series of meetings in order to establish the new unit on the Redlands' site.	
June 2010	Capital works programme for Redlands given budget allocation of $10.2M (for Barrett Adolescent Extended Treatment Unit) plus further budget allocation of $5.8M with anticipated cost of $18.8M (anticipated shortfall of $2.7M)	WMS.6006.0002.54354
July 2011	Dr Groves prepares Queensland Plan for Mental Health 2007 – 17 First Evaluation Report	
16 May 2012	Dr Tony O'Connell (then QH D-G) signs briefing note approving the cessation of the Redlands' Adolescent Extended Treatment Unit Program and provides the briefing note to the Minister's Office for approval.	DBK.001.001.0067
28 June 2012	West Moreton 2012/13 Service Agreement commenced operation for a period of one (1) year	
1 July 2012	*Hospital and Health Boards Act* 2011 commences operation.	
August 2012	Dr Jeanette Young (as Acting D-G, QH) signs a further briefing note approving planned strategy for targeted rectification of infrastructure issues and the planning for 12 rural hospitals (the funding for which is to come from a number of sources) including cessation of the Redlands' project. This briefing note is also signed by the then Minister, Mr Springborg.	

Date	Event	Delium Reference
October 2012	Deputy D-G, Dr Cleary, requests Queensland Health Infrastructure Branch to look at the prospect of refurbishing BAC. That month there occurs a meeting involving Dr Geppert, Dr Kingswell, Dr Gilhotra (all representing Queensland Health) and Ms Kelly (representing WMHHS). The day following the meeting, Ms Kelly sends an email to the other attendees noting that a brief has gone to the Minister and that, given that circumstance, the option is to close BAC as early as December 2012, given that all or most consumers go home for the Christmas break.	DVK.001.001.0075
8 November 2012	Dr McDermott testifies at the Queensland Child Protection Commission of Inquiry, publicly disclosing that he had been informed that BAC was to close by Christmas 2012.	
December 2012 through May 2013	Expert Clinical Reference Group (ECRG) meets.	
8 May 2013	ECRG report published.	WMS.0012.0001.08528
15 May 2013	Planning Group (Dr Stathis), Dr Sadler, Dr Kingswell, and Ms Cheryl Bond from RBH School meets.	WMS.1003.0027.00001
24 May 2013	WMHHB considers ECRG report and report of the Planning Group: "The Minister is to be updated regarding proposed closure, a plan for development of alternatives and community engagement strategy." and "The Board approved the development of a communication and implementation plan inclusive of finance strategy to support the proposed closure of BAC." and "The Board discussed the recommendation from the Planning Group that proposes the closure of the (BAC) and the issues that this presents. The Board recognised that the facility is no longer suitable but is concerned that there is currently no alternative for consumers."	WMB.1000.0001.00012

Date	Event	Delium Reference
15 July 2013	Meeting involving the Minister, Ms Dwyer, Ms Kelly and Dr Corbett.	
16 July 2013	Ms Dwyer notes that the Minister had given his support to proceed to closure following communication with D-G (Health), Department of Education, and Queensland Mental Health Commissioner.	
6 August 2013	Minister Springborg announces BAC closure decision on ABC radio,	(Audio-transcript COI.008.0001.0002)
26 August 2013	SWAETRI (subsequently AMATTI) Committee formed.	WMS.3001.0001.00657
10 September 2013	Dr Sadler stood down.	
10 September 2013	Dr Anne Brennan appointed Acting Clinical Director of BAC.	
September/October 2013	Barrett Centre Clinical Care Transition Panel formed and commences operation.	
31 December 2013	Barrett Adolescent Centre Special School closes at The Park and relocates to Yeronga.	
31 January 2014	BAC closes its doors for the last time.	
June 2014	A Schedule of Transfer is developed pursuant to which, notwithstanding enactment of the *HHB Act* and other legislation, staff employment responsibilities remain with the Department of Health until 1 July 2014 and ownership, *inter alia*, of the BAC building remained with the Department of Health until 22 December, 2014 (this had the effect that WMHHS could not control management of the building or land on which BAC stood at the time of the closure decision it not being the owner thereof, nor did the HHS employ staff at BAC which was still the responsibility of Queensland Health as System Manager).	
30 October 2014	Kotze/Skippen report delivered to Queensland Health.	
2015	Barrett Adolescent Special School relocates from Yeronga to Tennyson for the 2015 school year.	

5 Toward a contemporary model of care – the expert evidence

5.1 The Commission heard from a number of expert clinicians as to what was available and contemporary for adolescent mental health care and the distillation of the majority view appears in the Discussion Paper for Sub-Acute Extended Treatment authored by Sophie Morson.

5.2 The Discussion Paper concluded that an extensive review of the literature found limited compelling evidence regarding the benefits of extended inpatient care for most young people. Inexplicably given other oral evidence, the author of this paper was not called. The Discussion Paper noted:

> "*While inpatient units served to help stabilise acute mental health problems, and are a necessary part of the continuing of mental health care, the greatest gains for young people appear to occur in the early part of an admission. An extended admission with the rehabilitative focus may be warranted for a small sub-set of young people, with provision made on a case-by-case basis considering the needs of individual young people and their circumstances … the considerable risks associated with inpatient admission may pose a significant challenge to a young person's achievement of developmental mile stones in forging a meaningful and contributing life. These risks may be more pronounced if the unit is far from home and the admission is of an extended duration and/or incongruent with a young person's cultural background. Treatment gains including those offered from a rehabilitative prospect may therefore be undermined by the inpatient setting itself, if not carefully managed. An admission should be considered only once all other options have been exhausted, with inpatient care guided by a clearly articulated, evidence-based model of service*
>
> *Regardless of the length of stay, a young person will at some point need to be discharged to a less restrictive treatment. Consideration of inpatient care is inextricably linked to other treatment options along the continuum of care, with evidence suggesting that a young people {sic person} experiencing an extended admission may have more difficulties successfully transitioning into the community. … Research is increasingly demonstrating that comparable – or better – outcomes associated with inpatient care may be achieved in less restrictive settings. Having reviewed the available evidence base, it is proposed:*
>
> *i. most adolescents requiring extended inpatient care be stabilised in the nearest existing acute adolescent unit prior to discharge to less restrictive care, as per the state-wide model of service;*
>
> *ii. any proposed service for CYMHS be based on a clearly articulated model of service with explicit attention to addressing the risks outlined above; and*
>
> *iii. additional resources be directed towards establishing a comprehensive continuum of community-based adolescent mental health services across Queensland."*[2]

5.3 The array of expert evidence has provided a longitudinal view of the evolution of the mental health care for adolescents and young people yet Counsel Assisting single out only Dr Scott and Professor Hazell as having relevant expertise. It is clear that Dr Stathis, Professor McDermott, Dr Hoehn, Dr Brennan and also Dr Sadler are eminently qualified.

Dr Scott

[2] p85 Discussion paper

5.4 Counsel Assisting at paras 19-25 of their submission describe Dr Scott's evidence. It is only a partial representation of his evidence.

5.5 In his written statement, in particular, Dr Scott was highly critical of the ECRG process and in particular Dr Geppert's part in it. Unlike a number of other witnesses[3] his expertise was canvassed by Counsel Assisting.[4] There are a number of difficulties with his evidence including:

(a) A number of his opinions, the basis for which were open to challenge, for instance his opinion that he was not convinced that the buildings at the BAC were a decisive feature[5] were based in fact on only attending BAC once between 2002-2009.

(b) His statement[6] as to the possibility of the BAC being closed, that there was nothing else available was at a time where he conceded in cross-examination that he was not aware of the Resi's which had opened up[7], nor was he aware of the advent of step-up and step-down units planned to commence in 2017-18. He conceded in cross-examination that there was perhaps a small cohort of persistent eating disorders, psychotic or persistent mood disorders which may require in-patient care, but again conceded if there were smaller bed-based units available, his concerns would be ameliorated.

(c) Of particular significance in his evidence was his criticism of the ECRG process and his view that that process was subject to a 'direction' from the Planning Group which was limiting its scope. He annexes to his statement, Dr Sadler's caveats as to the appropriate model yet does not include emails which clearly disclose his and other members of the ECRG endorsing of the model.[8] Therefore despite his strongly worded statement, he conceded, at para 25 in cross-examination by Mr Harper for the deceased patients' mothers that he was not necessarily strongly of a view that there should or shouldn't be tier 3. This was despite a leading question from Counsel Assisting urging him to adopt a contrary view.

5.6 In response to Counsel Assisting's question as to whether it remained his view that a Tier 3 facility was necessary, Dr Scott said:[9]

> '*I am less certain about [that]…I think that there are possibly – there are other community models that operate around the world and other jurisdictions where there's specialist therapies available to provide care for young people in the community'*

5.7 In response to questioning as to the value of a Tier 3 facility as recommended by the ECRG, he said:[10]

> *I'm actually undecided upon that for a couple of reasons. I haven't worked within adolescent inpatient facilities as a director, as a consultant psychiatrist consistently since about 2010. I have done some periods of time working at it so – but – but I haven't had that consistent responsibility. I am aware that there's been some very interesting community-based programs developed overseas and in other jurisdictions that I think are well worth a look at. I'm also aware when I went back to look through the evidence about extended hospitalisations and how effective are – are they, there's a real lack of evidence about whether or not they work. So I'm not strongly of a view that there should be or shouldn't be a tier 3 model in place. I think that people need to have a really good look at*

[3] see for instance Dr Stathis, Dr Hohen
[4] See T8-4
[5] See T8-39 - 41
[6] Para 16
[7] T8-10
[8] See exhibits 174 & 175
[9] T8-8:30.
[10] T8-27:20-31.

what the evidence is and what the other alternatives might be before investing such a large sum of money into such a facility.

Professor McGorry

5.8 Professor McGorry was called, it seems as an expert, by Counsel Assisting. It must be remembered that Professor McGorry was briefed in the most limited of ways, given only four items on which to express a view:

(a) The statement of Dr Sadler

(b) The statement of Professor Crompton

(c) The statement of Dr Brennan

(d) A draft model of service purportedly for Redlands.

In oral evidence he only referred to the first and fourth documents apparently without any context.

5.9 There was no letter of instruction to Professor McGorry annexed and he makes various comments in his report as to material and commentary provided by the Commission, none of which is disclosed to the parties.

5.10 Professor McGorry's opinion on the cohort of Barrett patients is entirely based, it would seem, on Dr Sadler's statement.

5.11 It is predicated on an acceptance of assertions made in Dr Sadler's statement for instance, that the cohort represented for instance homeless, abandoned and young people in care. However, it was established with Dr Sadler that over his time at BAC there was only patient Dr Sadler

5.12 Furthermore, whilst there is an assertion by Counsel Assisting that all the patients had had recurrent failed admission to acute units[11], in fact this has never been established. For instance, the statement of was never admitted to Barrett, had not had presentations at other mental health facilities and no attempt had ever been made by the family to access CYMHS.

5.13 Dr Brennan in her oral evidence took issue with the severity or otherwise of the cohort, stating "that most of the young people admitted to Barrett were young people with severe and persistent mental health problems. … They were quite functional in many aspects of their lives."[12]

5.14 Whilst the passage from Professor McGorry's evidence is set out in Counsel Assisting's submissions, the important qualification that he was unaware of the details of the transition, had no knowledge of other services available in Queensland and limited knowledge of the BAC cohort, is not included. Hence his evidence, sought to be relied upon as an expert, does not meet the most basic requirements in terms of an expert opinion being briefed and other than in general terms does not assist the Commissioner.

Doctors Breakey, Ward and Sadler

5.15 Counsel Assisting called Dr Breakey and Dr Ward prominently as the first and second witnesses at the commencement of the oral hearings.

[11] 57A
[12] T20-20.15-20

5.16 The evidence highlighted in their submissions indicates that Dr Breakey is supportive of the "*model*" which Barrett exemplified.

5.17 This ignores the following:

(a) He is an admitted advocate for BAC.

(b) He is not and was not a Fellow of the Royal Australian and New Zealand College of Psychiatrists but of general practitioners.[13]

(c) Dr Breakey has only locumed in the last 4-5 years for very limited periods of time at BAC,[14] sometimes only 1 day per year, 1 year no days, another approximately 17 days.

(d) He was unaware of services such as the "*resi's*"[15] and the service at Lady Cilento Children's Hospital[16] and had limited knowledge of AMYOS.

(e) His criticisms of Headspace at para 54 were never put to its architect, Professor McGorry.

(f) His acknowledgement of the high rates of self-harm at BAC and the contagion effects were not included in these submissions.

(g) He advocated that transitional discharge should occur from day 1[17] but failed to acknowledge the absence of evidence that this occurred at BAC.

5.18 Dr Ward is specifically referred to by Counsel Assisting for his doctoral research. It appears that he was relied upon because he in turn was mentioned in the discussion paper of sub-acute beds[18] but curiously the author of that document has not been called. Some mention should be made of his evidence.

5.19 Dr Ward accepted that the data he collected over 16 months precluded him from conducting family therapy at BAC. He was the only social worker working at BAC at that time.

5.20 His study of adolescents:

(a) was not representative of even the cohort at BAC because it did not include those who were not well enough or emotionally stable enough to participate. Furthermore, others refused.

(b) Only out of the adolescents were interviewed on three occasions.

(c) As Professor McDermott noted, of the adolescents were on involuntary treatment orders, which clearly had specific mandates for treatment and outcomes. Professor McDermott was critical of the research whilst commending the fact that it had occurred. As he noted,[19] it was approximately 2% of a population of 600 over 25 years.

(d) Professor McDermott pointed to the bias inherently arising from the fact that Dr Ward had worked at the Unit for some eight years.

[13] 6-35
[14] T6-43
[15] T6-39-40
[16] T6-41
[17] T6-44
[18] CHS.500.0001.0001
[19] T7-63 line 10 & 30

(e) What is also not included in any evidence referred to in the submissions is at 6-66 – a direct quote from a patient who said that the length of stay as an adolescent had in fact worsened treatment. Nor that some young people would sabotage their treatment[20].

(f) Dr Ward had limited or no knowledge of alternative services, for instance, day programs or Resi's.

(g) He remained an admitted advocate of BAC.

5.21 Dr Sadler was at the time of his the Clinical Director for some 25 years. It is apparent that he was deeply personally invested in BAC. This is in no way a criticism of him, but inevitably colours his view.

5.22 He remains a staunch advocate for it despite:

(a) The BAC never having a formal model of service delivery.

(b) The two critical reviews of 2003 and 2009, the second of which he simply refused to accept as having merit.

(c) His involvement in the 2010 AETRI process, which highlighted the deficiencies of BAC and the preponderance of views regarding aspects such as length of stay which was contrary to his own.

(d) The lack of evaluative evidence to support the efficacy of the BAC[21]:

"*those young people who were in BAC who subsequently Some years ago I was aware of we had treated at that time… that is substantially higher than the prevalence for the age group .. However, from the high rate of subsequent it could be argued that we are not very effective."*[22]

Professor McDermott

5.23 Professor McDermott's[23] expertise was not identified by Counsel Assisting, but is clear from his curriculum vitae he has extensive experience in delivering treatment to complex trauma patients.

5.24 His evidence was of particular interest for a number of reasons. Although it is not referred to by Counsel Assisting, he referred to a number of important factors:

(a) That it was essential for a health facility to have a model of service delivery[24].

(b) When he was asked about gaps in alignment of adolescent and adult mental health services as follows:

"*There is a gap. Services stop and other services start. One of the things that people need to understand is that often the conditions treated by those two service sectors are actually very different. So, for instance, adult mental health is much more exposed to and has to respond to psychosis, manic depressant psychosis and bipolar disorder. Child and adolescents are much more exposed to dysregulated behaviour, chronic self-harm, depression and anxiety. So there will always be a gap, partly because the conditions are different. … Now does transfer between the two services happen? Yes. Does it happen well? Well it's very variable. … and it depends; it's*

[20] T6-66 line 35
[21] See his email to Professor Martin July 2013 WMS.6006.0002.57727
[22] Ibid
[23] T7-24 & following
[24] T7-58

probably on a condition by condition basis. The transfer of psychosis, I suspect, happens really very well because, again, that's a really core expertise of adolescent mental health. The transfer of things like complex PTSD and borderline functioning would happen less well, anxiety disorder generally less well, eating disorders quite well. So it's a sort of illness by illness proposition."[25]

(c) He also provided cogent evidence as to the risks of institutionalisation.

(d) His evidence that none of the beds that were made available at the Mater Hospital under his tenure were taken up by patients from BAC for admission of patients.

(e) His evidence regarding the features of institutionalisation in general terms that 'you [are] in danger of taking up some, if you like idiosyncratic … behaviours and elements of that new environment'[26] and in particular with BAC:

"*They mostly had complex diagnoses and most of them had a trauma as part of – trauma is part of their presenting ….and if you had for instance regressed behaviour and people were doing things for you, you might learn regressed behaviour. Periodic exposure to endemic rates of self-harm you might pick up self-harming*."

(f) He also had altered his views about the viability and advisability of having schooling as part of any inpatient treatment, noting they were a group of young people who, if they became aroused or acutely agitated or disturbed, had none of the scaffolding that had been there at the Barrett Adolescent Centre.[27] He was completely disapproving of this. He contrasted this unfavourably with the Mater School.

(g) He also was of the view that it may in fact only be 3-4, or a very small number of young people who may in fact require, in his view, a constant need for a very small number of beds (3-5), i.e. a small number of individuals who have such profound levels of need that they need more than a step down and they shouldn't be an inpatient.

(h) Professor McDermott was also able to give very particular evidence about other services which existed such as ADAWS, AMYOS, CYFOS the use of tele-psychiatry and latterly the multi-systemic theory.[28] He was also complimentary of the acuity of young people being treated at day programs. His evidence is seminal in relation to the need, which on his evidence would, at most be 3-5 persons, whose acuity may need more than a step down facility.

(i) He also provided a snapshot of how was managed within the Hospital and re-introduction to mainstream schooling.

Dr Stathis

5.25 Counsel Assisting seeks to minimise the evidence of Dr Stathis due to his "*antagonistic attitude*" in the witness box[29], which omits any reference to the type of questioning of him by Counsel Assisting.

5.26 Counsel Assisting did not explore with Dr Stathis:

(a) His extensive experience which would have been particularly relevant to the Inquiry, given his years of experience as a clinician with adolescents.

[25] T7-56 from line 1-16
[26] T7-61 line 19 & 20
[27] T7-62 line 25 and following
[28] T7-52
[29] Para 64, p.18

(b) His current position within Children's Health Queensland.

(c) His involvement in the Planning Group undertaking.

(d) His intimate understanding of services available to adolescents.

(e) His involvement with the ascertainment of sub-acute beds at the Mater Hospital and then Lady Cilento Children's Hospital.

(f) His information and presentation to BAC carers/parents in December 2012 [30]

(g) His involvement with transitional funding for ex-BAC patients.

5.27 He also was not asked to comment in relation to the discussion paper by Sophie Morson, which one would have expected given it is a seminal work and its contemporaneity, having been promulgated only in January of this year.

5.28 His evidence was that he commissioned it because Dr Daubney, who himself is an eminent child and adolescent psychiatrist, had been tasked with the formulation of the model of service delivery for sub-acute beds and had only been able to find a very limited evidence base for it. This in itself would have given one pause for thought, and as a consequence the Discussion Paper was commissioned by Dr Stathis.

5.29 Dr Stathis' evidence was that he publicised the availability of the sub-acute beds at a meeting of the College of Child and Adolescent Psychiatrists in November 2013, with little uptake. Far from demonstrating his antagonistic view, it indicates that he was open to and had taken significant steps towards ascertaining a thorough and comprehensive overview of the groups or cohort of young people who may require extended inpatient admission.

Professor Hazell

5.30 Professor Hazell's evidence is again referred to in some detail by Counsel Assisting. However there are a number of matters he raised which are not included in Counsel Assisting's submissions.

5.31 He for instance was aware that there was no longer funding to rebuild a BAC, but he considered that unavailability was not necessarily antagonistic to the development of a model of care for tier 3.[31] Whilst he expressed strong views on alternatives to a tier 3, he accepted quite properly, that he was not aware of the continuum of services then and now available in Queensland.

5.32 He clearly articulated the differences between BAC and both the Rivendell and Walker units. For instance there was clearly a model service delivery for Rivendell and a more precisely worded framework for Walker.[32] He emphasised that referring agencies continued to have a significant role in the treatment of young persons and accepted in part so that they had some "*skin in the game*" but also what is do-able in the community..12-26].

5.33 Prof Hazell from the Walker unit (with the most seriously ill adolescents [Prof Hazell XN McMillan 8-45.20-22]) stated six months is the median length of stay and for a long time it had been the median length of stay at Rivendell, but it was not an absolute but a guide. His experience was that the goals set for the patients could be achieved in that time and the 28 day readmission rate was zero (save that patients may be lost to other services) [Prof Hazell XN McMillan QC 8-44.10-20].

[30] statement Leanne Geppert
[31] T8-33
[32] See T8-36

5.34 He also was clear that the average length of stay at the Walker Unit was six months, although there were a couple of outliers.[33] He clearly articulated that long-term inpatient stays had complications for young people such as being away from family and school. He also referred to transference as a risk of an in-patient environment. The lack of readmission suggested that there was no acuity immediately after discharge [Prof Hazell XN McMillan QC 8-44.31-33]. Longer periods in hospital give rise to longer periods of absence from normative experiences and carry the risk of transference [Prof Hazell XN McMillan QC 8-44.44 & 8-453-5]. Upon global assessment, two-thirds of his patients had improved upon discharge, one-third stayed the same and no one got worse. The global assessment of function measures used are the most reliable indicators of how people are going to do in the longer term [Prof Hazell RX CA 8-48.13-22].

Conclusion

5.35 In essence there was a consensus amongst all clinicians, that contemporary care where at all possible should occur as close as possible to a young person's home and community.

5.36 There was no peer reviewed literature which promoted extended inpatient treatment for even the most significantly affected young people. Facilities such as Walker and Rivendell in Australia which cater to severely impaired young people, such as those with psychosis, have six months as the outer limit [34]. In fact, the evidence base to support extended inpatient treatment of the kind provided at BAC could not be found by Dr Daubney.

5.37 The majority expert view was also consistent with the following extract of the Morson discussion paper:

> *"While inpatient units served to help stabilise acute mental health problems, and are a necessary part of the continuing of mental health care, the greatest gains for young people appear to occur in the early part of an admission. An extended admission with the rehabilitative focus may be warranted for a small sub-set of young people, with provision made on a case-by-case basis considering the needs of individual young people and their circumstances … the considerable risks associated with inpatient admission may pose a significant challenge to a young person's achievement of developmental mile stones in forging a meaningful and contributing life. These risks may be more pronounced if the unit is far from home and the admission is of an extended duration and/or incongruent with a young person's cultural background. Treatment gains including those offered from a rehabilitative prospect may therefore be undermined by the inpatient setting itself, if not carefully managed. An admission should be considered only once all other options have been exhausted, with inpatient care guided by a clearly articulated, evidence-based model of service.*
>
> *Regardless of the length of stay, a young person will at some point need to be discharged to a less restrictive treatment. Consideration of inpatient care is inextricably linked to other treatment options along the continuum of care, with evidence suggesting that a young people {sic person} experiencing an extended admission may have more difficulties successfully transitioning into the community. … Research is increasingly demonstrating that comparable – or better – outcomes associated with inpatient care may be achieved in less restrictive settings".*

5.38 As Dr Stathis stated in his evidence, long stay facilities around the world are being closed not opened.

5.39 The majority of clinicians did not advocate for a Tier 3 "build" and were of the view that the array of the services below would cater for most young people:

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[33] T8-43-44

[34] except for "outliers" as Professor Hazell referred to

(a) AMYOS (Assertive Mobile Youth Outreach Service) designed and run by Dr Daubney was a service operating in Victoria and was underpinned by an evidence based model of care called mentalisation based therapy [Dr Scott XNCA 8-8. 45-47 & 8-9. 7-9]. It allows them to care for a much higher level of severity of illness in young people than what could normally be managed by a standard CYMHS [Dr Scott XNCA 8-9.13-15]. It is part of a suite of services that would suit all but the small proportion of patients who can't be supported in day programs who need residential care but the aim is in any event to get them back to community [Dr Scott XN Wilson 8-12 to 8-13.24]. There are nine teams across Queensland[35].

(b) Day programs – intensive community based support which cannot be met through outpatient support but are not severe enough to warrant admission.

(c) Youth Resi's – aim to assist young people who require long term accommodation and recovery oriented care, including life skills and to acheive and maintain independence. One opened in February 2014 and [redacted] is resident there and on all accounts progressing well. [redacted]

(d) Step up, Step down units – have shown positive benefits in Victoria and appears to be widely subscribed. Such units allow 16-24 year olds short term residential accommodation support to avoid an inpatient admission ("step up")or following discharge ("step down"). There is currently none is Queensland.

(e) Sub-acute statewide beds – as the discussion paper notes, those was included in the AHMETI model of care, in turn based on the ECRG recommendations. As the unchallenged evidence demonstrated there is has been minimal uptake for these – only [redacted] young people required them over 18 months[36].

5.40 The unchallenged evidence is at most [redacted] young people [37]may require the last category of care. It is telling, that arguably only [redacted] of the [redacted] young people discharged/transitioned from BAC in 2013/14 required this level of care. In 18 months, only [redacted] patients are recorded as having taken up the sub acute beds.

6 Reasons to close BAC

6.1 BAC never had a formal model of care. It was apparent from the two external reviews that the lack of a formal model was a criticism.

6.2 Whilst Dr Sadler contended in his second statement to written models, he conceded eventually that approximately half were attributable to BAC and probably the other half were to the "Redlands" project. It is apparent on their reading that they are two distinct categories of documents. Neither was any model of care for BAC submitted to the Mental Health and Other Drugs Branch (MHAODB) despite Dr Sadler knowing it was a requirement for endorsement. When asked as to evidence of the model of care being actioned from the review, none was forthcoming.

6.3 This is more than a formal matter. Professor Hazell opined that a comparable unit would never be undertaken and begs the question why otherwise the AITRC, including Dr Sadler, was established to address this shortfall[38].

[35] Sub-wide acute Discussion paper p7
[36] Ibid p7
[37] professor McDermott
[38] Minutes of AITRC – 10/2/10 – 19/2/10

6.4 Ms Dwyer acknowledged that she was not a mental health clinician. However she was advised (by Dr Kingswell and Dr Leanne Geppert, Dr Terry Stedman, Dr Darren Neillie and Ms Kelly) and was able to confirm by considering the operations of BAC, that the BAC model of care was contrary to the contemporaneous model, which emphasised community-based, locally-provided non–institutional care for patients not requiring acute admission [Ms Dwyer XNCA 12-96.22-35].

6.5 The BAC building was not purpose built, was effectively past its useful life, which necessitated ongoing patient management techniques to compensate for these shortcomings. Ms Kelly said in evidence that "in all of the documentation and all of my conversations to me, it was the actual physical buildings of the Barrett would no longer be able to do what they were doing for those past years" [Ms Kelly XNCA 11-12.26-29]. The ACHS had found that the aged building was problematic [Dr O'Connell XNCA 12-17.25-27].

6.6 Redlands was chosen as the preferred site for the new adolescent MHS. A new building at a different site on The Park campus was rejected as not feasible, and progressive rebuilding at the present site at The Park was determined to be less desirable than Redlands. The Site Option Report 2008) [39], specifically identified close proximity to the growing high security and extended treatment forensic program as compromising such an option.

6.7 The Redlands project progressed in a substantive sense as follows:

(a) A user group was appointed [Prof Crompton XN Mellifont 7-20.32-38]), and a smaller core group formed to inform AETRC, tasked to guide the design and development of the new "Adolescent Extended Treatment and Rehabilitation Centre on the Redlands site". Prof Crompton established the group. [Prof Crompton, CAQC 7-3.40-43, [34] of witness statement]. The user group comprised members from Mental Health Branch of Queensland Health and Health Planning Information Division of Queensland Health (HPID). HPID was responsible for making decisions in relation to the progress of the AETRC project. [Prof Crompton RX CA, 7-21.1-5]. Mental Health Branch were ultimately responsible for signing off on the model of service delivery in that they needed to approve what the user group were doing. In respect of the model of service delivery the subject matter expert reported back to FPTM relying on their collective expertise as to what was required in the context of child and adolescent services [Prof Crompton RX CA7-21.12-20].

(b) Land was purchased. It was acquired within 12 months or so of the Queensland Plan for Mental Health being approved by Cabinet [Dr O'Connell XN CA 12-9.34-36]

(c) Significant work was done including site surveys, drafting of architectural plans and engineering planning.

(d) Significant work was done on developing a model of care and presentations in respect of that model were made to the user group by Dr Sadler [QHD.003.001.2655] with the model being finalised by approximately 22 July 2010 [Prof Crompton XNCA 22 &27-28].

6.8 The Redlands project encountered multiple delays [Prof Crompton XNCA7-7.26-27] and difficulties related to site limitations (eg., flooding susceptibility [Dr O'Connell XNCA 12-11.3-11] , environmental issues (eg., koalas [Dr O'Connell XNCA 12-13.42-44] [Prof Crompton, XNCA, 7-9.10-12, 44-47], [Dr Geppert XNCA 10-51-4], changes in the proposed clinical service model (to be proposed externally by a group of experts) [Prof Crompton, XNCA 7-8.17-26, 7-20.5] cost over runs estimated at one time at $1.4m [Prof CromptonXNCA7-7.43-45] [Dr Geppert XNCA 10-4.24]. They were considered unresolvable at the time [Dr Geppert XNCA 10-5.1-5].

[39] WMS.5000.0031.00190

6.9 Dr Kingswell explained that the "envelope" for building on the site was consequently decreased by those issues. It was also clear that multi or even double storey facilities were not feasible for these patients.[40]

6.10 Delays were also occasioned in confirming the model of service delivery which was to inform the project definitions and schematic design. There had to be consensus on how exactly the patients were going to be serviced. What percentage of patients would require long term residential care, what facilities and services other than purely nursing care and psychiatric care would be required so the whole decision about what percentage of the patients were going to be serviced in the community rather than as inpatient in long-term residential extended care. The process of determining the model of service was going through ongoing stakeholder engagement and discussion amongst relevant parties [Dr O'Connell XNCA 12-10.6-15].

6.11 In May 2012 the Director General was requested to cease the Redlands project [Dr O'Connell XN Fitzpatrick 12-28.11-13]. It was ceased for a number of reasons including an emerging clinical preference to care for patients in more community based, closer to home models being the most important factor. Budgetary constraints were second and project delays were third [Dr O'Connell XN Fitzpatrick 12-28.27-35]. The Director General cancelled the Redlands project [Dr O'Connell XN O'Sullivan 12-42.36-37] on the recommendation of Dr Kingswell [Dr O'Connell XN O'Sullivan 12-45.20-21].

6.12 West Moreton Health Service District (as it then was) was not consulted as to the impact of cessation of the Redlands project on BAC or the services it then provided.

6.13 The first notification to WMHHS that the Redlands project was not proceedings was via a memo from Glenn Rashleigh of the Health Infrastructure Branch sent to Lesley Dwyer of WMHHS and Dr Richard Ashby of MSHHS advising that a decision of the government had been made to cancel a number of capital delivery projects including the proposed "replacement adolescent mental health unit at Redlands"(RAETU) [Prof Crompton XNCA,7-5.5-10, 34-40].

6.14 At this point in time:

(a) The development of the EFTRU was well advanced and EFTRU was expected to come into operation in mid 2013. This project was part of the QPMH and had been in train for some years. The ET&R consumers (previously accommodated in the buildings to be re-commissioned as EFTRU units) were being decentralised and moving into community care [Ms Kelly XNCA 11-4.13-17].

(b) There is evidence going back to briefing documents and the Site Options Report concerning the Redlands project that it was considered inappropriate to co-locate the adolescent service with EFTRU. [Dr O'Connell XNCA 12-23.15-19].

(c) There was a firm view within MHAODB that BAC was not a contemporary model of care. The advice Ms Dwyer received from people more expert than she, was that the model of care was no longer considered to be contemporary [Ms Dwyer XN O'Sullivan 12-120.37-40]. The information she received included from Dr Kingswell and Dr Cleary [Ms Dwyer XN O'Sullivan 12-121.34-36].

(d) The BAC building was in poor condition and had been the subject of ACHS adverse reports. The ACHS had stated that BAC was in urgent need of replacement [Dr O'Connell XN Fitzpatrick 12-32.1-11].

(e) Little action had been taken to address the operational and governance issues identified in the 2003 and 2009 external reviews.

[40] Dr Sadler

(f) There was still no model of care for BAC.

7 The decision to close BAC

7.1 Sharon Kelly commenced as the Executive Director MH&SS for WMHHS on 17 September 2012. She was on leave between 30 August 2012 to 14 September 2012 (Ex 66 Statement of Ms Kelly). On 25 October 2012 (Ex 66 & WMS.9000.0006), she attended a meeting with MHAODB (Drs Kingswell, Gilhotra and Geppert, who held the positions of the Executive Director of MHAODB, the Chief Psychiatrist and the State Director of Planning) for the purpose of being briefed on mental health services in WMHHS generally, current operations and future plans for each of the units within The Park operations and mental health services.

7.2 In that meeting, Ms Kelly was advised by, probably, Dr Kingswell, that BAC was not considered by MHAODB to be part of the service model for the delivery of adolescent mental health services going forward, and BAC was not aligned to future planning for The Park or to the QPMH [Ms Kelly XNCA 11-5.1-16]. Ms Kelly confirmed in an email to Dr Kingswell the following day her understanding of his advice on a range of matters advised to her at the meeting including that the closure of BAC was not optional, however needed to be planned [Ms Kelly XNCA 11-14 & DNZ.001.002.0050].

Statutory framework

7.3 The statutory framework for the delivery of health services in Queensland is discussed in **Appendix A** to these submissions.

7.4 Neither WMHHS nor WMHHB had the legal authority to 'decide', nor were either asked to decide, to close BAC. The decision to close BAC had been made in around 2007/8. To the extent that the cessation of the Redlands project was of relevance, the clear advice to Ms Kelly by Dr Kingswelll was that the decision to close BAC was unchanged. That is perhaps unsurprising given that the reasons for closing BAC had not changed.

7.5 The extent of WMHHS and WMHHB's role and responsibility was to determine the timing of closure and how to do so, subject to the concurrence of the Department.

7.6 In considering those matters, WMHHS and WMHHB were to a degree time-limited, due to the impending opening of EFTRU and, to a lesser extent, the recognition that the BAC building and model of care were not an optimal therapeutic environment.

7.7 As at late October 2012, when Dr Kingswell advised Ms Kelly that BAC was not aligned to future planning for The Park or to the QPMH and needed to be closed, WMHHS and WMHHB were placed in the following situation:

(a) There was no funding for an alternative 'bricks and mortar' adolescent extended treatment and rehabilitation facility.

(b) Continued operation of BAC at its current site past the commissioning of EFTRU was contrary to accepted risk assessment and that risk could not be tolerated in the long term.

(c) Advice/direction from MHAODB was that BAC was not a contemporary model of care and was to close (notwithstanding the cessation of the Redlands project).

7.8 The primary concern and objective of WMHHS was to ensure closure of BAC could be implemented and how to do so safely

7.9 To that end, WMHHS established a governance structure and process (reflected in the Project Plan (Project Plan dated 16 November 2012 SK10 to Ex 66). Underlying the Project Plan were stated, externally dictated parameters that:

(a) Dr Scott said that the ECRG knew, as Dr Geppert had outlined, that there was no capital funding available that would be allocated for a tier 3 service [Dr Scott XN McMillan QC8-20.8-12].

(b) The decision that funding had been reallocated had occurred by at least 16 November 2012 see WMS.0012.0001.04639 (WNHHS Project Plan – project starting 16.11.12); and

(c) BAC as a physical facility had to close.

7.10 It is entirely without credibility to suggest that if petitioned for, the funds would have been found for a 'capital funding' project to replace the cancelled Redlands project or the BAC. Such a proposition flies in the face of:

(a) The cancellation of the Redlands Project and diversion of funding to other initiatives.

(b) The fiscal environment then being imposed by the Department and throughout government.

(c) The unequivocal evidence of Dr Kingswell, MHAODB regarding the shortcomings of the model.

(d) The fact that relentless petitioning of the Minister by advocates of the BAC, including assertions that adolescents lives would be put at risk, failed to provoke a change of position by the Minister.

(e) The fact that the new models proposed by Children's Health Queensland are yet still subject to a progressive roll out due to apparent funding constraints.

7.11 Pursuant to the Project Plan and with joint involvement of MHAODB, an ECRG was established with a remit as described in the ECRG Terms of Reference [WMS.1002.0002.00091].

7.12 Item 2.1 of the Terms of Reference says "the ECRG will consider that the models of care will clearly articulate a contemporary model's model of care for subacute mental health treatment for adolescents in Queensland, and will be evidence based "JAS8 p94 statement of Scott the group was to consider and articulate a contemporary model of care, evidence based, sustainable, in line with the Queensland Mental Health Policy, will take into account the clinical services capability and will replace the BAC. The reasons were more than the state of the building and its co-location [Dr Scott XN McMillan QC 8-15.43 to 8-16.4]. The ECRG met between about December 2012 and March 2013 on at least six occasions.

7.13 The ECRG had broad representation from Child & Adolescent psychiatrists, (Dr Scott, who obtained his fellowship as a child and youth psychiatrist in 2001 and who had worked in that field in the community and acute settings since that time, was a member [Dr Scott XNCA, 8-3.34, 8-4.7-11, NGOs (eg., Ms Callaghan from "Headspace" [Ms Callaghan XN CA 8-54.19]), education, consumer and carer representatives. There were 12 members. The group was made up of a substantial number of practising clinicians with a wide array of clinical experience in the child and youth mental health sector from various disciplines. One of the strengths of the group was that it wasn't just a medical group. It included psychologists, allied health and nurses [Dr Scott XNCA 8-4.17-29].

7.14 It was to come up with a contemporary model of care to replace BAC [Dr Scott XNCA 8-4.35-37]. Above the ECRG sat the Barrett Adolescent Strategy Planning Group which included the

practising clinicians, Drs Sadler, Stathis and Hartman [Dr Scott XNCA 8-4.45 to 8.5-4] and WMS.1002.0002.00070. Dr Geppert was also a member.

7.15 At the first ECRG meeting on 7 December 2012, Dr Geppert advised that "BAC cannot continue on the current site and there is no funding to build another BAC" {WMS.0012.0001.15298 summary & Dr Geppert XNCA 10-15.10-14]. Dr Scott said at the first ECRG Dr Geppert said that Redlands had been cancelled [Dr Scott XN McMillan QC 8-16.35-37].

7.16 The ECRG report [JS12 @ p 133 of statement of Scott] or WMS.60006.002.33021 (recommendations):

(a) used the terminology tier 3 service, a concept not used within the Queensland or Australian mental health services lexicon. Ultimately and unanimously it recommended there should be a tier 3 facility [Dr Scott XNCA, 8-6.34 and 8-7.1-2] and WMS.1002.0002.00070, "members of the ECRG unanimously supported the retention of the tier 3 option in the recommended service model" [Prof Hazel XNCA, 8-36.25-29]

(b) referred to tier 3 service, not a tier 3 building [Dr Geppert XNCA 10-19.42]. Dr Geppert said, "there was no funding for a replacement bricks and mortar service to be developed. That didn't mean, of course, that we couldn't develop models of service and ways of delivering care to that particular cohort, but there was no capital funding to actually build a bricks and mortar building" [Dr Geppert XNCA 10-15.17-21]. Prof Hazell said he knew of the lack of capital funding when he was a member of the ECRG and interpreted the lack of funding to mean a "new build was off the table. But there could have been other creative solutions such as refurbishing an existing facility, finding an alternative accommodation for the service" [Prof Hazell XNCA 8-33.43-46];

(c) proposed an 'ideal' model [Dr Geppert XNCA 10-16.7], ie not constrained by budgetary limits [Dr Geppert XNCA 10-16.8-10].

(d) Notwithstanding there being no budget specified in the Terms of Reference [Dr Geppert XNCA 10-17.35], the ECRG report recognised the prospect of BAC closing prior to any tier 3 service being available, noting that there were risks in that scenario and that 'interim services' would be required. The caveat to the recommendation in the report said (in a footnote) "until funding is available for tier 3, all young people requiring extended treatment and rehabilitation will receive services through tiers 1 and 2A, B ie., utilising existing CYMHS community mental health day programs and acute inpatient units until the new day program and residential service providers are established" [Prof Hazel XN McMillan QC 8-46.23-28 & MNH.900.003.0098] and "while tier 3 options are established must prioritise the needs of these individuals and their families and carers. Wraparound care for each individual will be essential".

7.17 Dr Corbett said that the recommendations included that a tier 3 should be prioritised, and if it wasn't "that other options including these wraparound care individualised care plans should be developed". She read it as "recognition that the ECRG realised a tier 3 service was likely not to be available immediately and that alternate options were to be provided" [Dr Corbett XNCA 9-47.1-7]. WMHHS was to pursue discharge of appropriate current patients with appropriate wraparound services, being those services provided to meet the individual needs of each patient [Dr Corbett XNCA 9-48.22-27].

7.18 Ms Dwyer said that the ERCG did recommend a tier 3 service be in place, however the group of adolescents that remained at Barrett closer to the time of closure – there was not a recommendation that any of those particular adolescents would be requiring a tier 3 service [Ms Dwyer XNCA 12-99.17-21]. There had been a decision to establish a tier 3 service but there was going to be a gap from the closure of the Barrett until that was established [Ms Dwyer XNCA 12-99.28-29;

7.19 The ECRG report did not say that the risks of not having a tier 3 service could not be managed. To the contrary, the report implies that it is a matter of recognising and managing those risks. It says in the recommendations at paragraph (a), "safe high quality service provision for adolescents requiring extended treatment and rehabilitation requires a tier 3 service alternative to be available in a timely manner if BAC is closed" [Dr Scott XN Allen QC 8-29.40-43]. It goes on to provide a recommendation as to mitigation of the risk, namely the interim service provisions [Ms Kelly XNCA 11-27.16-19] Ms Dwyer said that the fact that the ECRG identified alternative options for the care of this cohort of patients and endorsed that the risks for these patients could be effectively managed if BAC closed was the advice she received [Ms Dwyer XNCA 12-98.13-19];

7.20 Nor did the ECRG report say that BAC could not be closed safely.

7.21 The ECRG report did not say that the current cohort of BAC patients (or any of them) required a T3 service. In evidence as adverted to earlier in these submissions, Dr Scott was less certain that what the BAC cohort needed was a tier 3 facility. He said

> *"I think there are possibly – there are other community models that operate around the world and other jurisdictions where there's specialist therapies available to provide care for young people in the community. As a rule, as an absolute rule, young people are best cared for at home with their families. So whenever that can take place it should. What that often requires is extra disability support. It requires specialised and intensive therapy to be available in community setting. And when those other services aren't available – and also extra educational support as well, schools being willing to look after these kids and educate these kids. When those aren't available, that's where we sort of find that young people cant be managed in the community and, thus, are needing an inpatient facility to look after them" [Dr Scott XNCA 8-830-41].*

7.22 AMYOS (Assertive Mobile Youth Outreach Service) designed and run by Dr Daubney was underpinned by an evidence based model of care called mentalisation based therapy {Dr Scott XNCA 8-8. 45-47 & 8-9. 7-9]. It allows them to look after a much higher level of severity of illness in young people than what could normally be managed by a standard CYMHS [Dr Scott XNCA 8-9.13-15]. The guiding principle being that young people are to be treated close to their homes in the least restrictive environment consistently with the Queensland Mental Health Plan [Dr Scott XN McMillan QC 8-16.40-44];

7.23 The ECRG did not say that the current cohort of BAC patients (or any of them) could not be safely managed via 'interim arrangements'. The service they were afforded was enriched care available through the usual CYMHS community services. They were allocated case managers to meet the needs of the young person and their families [Dr Scott, XNCA & Commissioner Wilson 8-7.41-45;

7.24 Importantly, the ECRG was endorsed by members of the group save Dr Sadler's caveats [Dr Scott 8-23.18-19 and Exhibit 174 & 175.

7.25 What flows from the ECRG report was that "The closure of BAC was not reliant on a final, State-wide service model...it was dependant upon making sure that every adolescent that we had in our care at that particular point in time was provided with appropriate services moving forward...that meant that each of those individual adolescents or young adults would have been identified as [to] their needs and an appropriate package of care or wrap-around service was developed individually" [Ms Kelly XNCA 11-17.43 to 11-18.9].

7.26 The ECRG simply stated that closure without a tier 3 being available carried 'risk'. Dr Scott said, "the risk was referenced to without a tier 3 facility risk to themselves and without adequate supports" [Dr Scott XN Wilson 8-2340-43 and his statement at para 64 and following].

7.27 The issue, therefore, was one of management of that risk, not that closure ought not occur. In that regard, it was reasonable and necessary to balance the risk to patients of remaining at BAC for some indeterminate period whilst a tier 3 was established, (in circumstances where it is

questionable how many of those patients would be best served by a tier 3 service in any event) as against the risk associated with transition. These risks included:

(a) Risks presented by co-location with EFTRU once that service was operational, which included the unacceptable risk of a BAC patient forming an attachment or friendship with a forensic patient [Breakey, XX Mc Millan QC 6-52.12-15].

(b) Risks associated with the BAC having to contend with continued, indefinite uncertainty regarding the future.

7.28 The ECRG reported to the Planning Group which was chaired by Ms Kelly [Ms Kelly XNCA 11-18.30]. The Planning Group was broad in representation (including Dr Stathis, Ms Bond, Dr Kingswell, Dr Sadler [Ms Kelly XNCA 11-20.26-33])and had a remit which was different to and broader than the ECRG [refer Project Plan].

7.29 The Planning Group recommended acceptance of the ECRG recommendations with caveats [Ms Kelly XNCA 11-24 to 11-25].

7.30 The Planning Group report was submitted to the health service chief executive, Lesley Dwyer, who submitted a recommendation to the WMHHB that closure of BAC be supported and "the Board supported closure at that time – subject to safe and appropriate transition of patients" [Dr Corbett WMB.0999.0001.00001 @28 para 18.5 & XNCA9-48. 35 to 9-49.3;WMB.9000.0002.00 page 130 – statement of Eltham].

7.31 The Board minutes "don't record a decision by the Board to close BAC because there was not a decision taken by the Board to close the BAC...the discussion was really around were we going to be able to ensure that there was going to be adequate care for the residents of the BAC if they had to make a transition to alternative care arrangements." [Mr Eltham XN CA 9-3.20-25] Mr Eltham said, "whether its the Board closing the BAC, that's not necessarily an inference you could draw from there. Simply, we were moving towards a situation where it appeared increasingly likely that we would have to transition the residents from the adolescent centre to alternative care arrangements" [Mr Eltham XNCA 9-3.33-36].

7.32 In the Planning Group recommendations (p176 of Mr Eltham's statement) there was an implicit view being expressed that BAC would be closing at some point. [Mr Eltham XN CA 9-5.18-19].

7.33 The Minutes of the meeting of the WMHHB on 23 May 2013 are reflective of the action taken not the content of the discussion, despite what Counsel Assisting assert.

7.34 That action was based on:

(a) The advice of the Planning Group and the ECRG.

(b) Knowledge that MHAODB had advised BAC was to be closed.

(c) Knowledge that EFTRU was proceeding, was to open within months and that there were risks to the BAC adolescents of co-locating the two patient cohorts.

(d) Advice from West Moreton Mental Health Services (in the Board Paper) as to the make up of the BAC cohort including their age and anticipated discharge trajectory.

7.35 WMHHB accepted the advice provided by the HSCE and MH&SS and supported closure of BAC subject to:

(a) "safe and appropriate transition of patients" [Dr Corbett XNCA 9-48.35-45 & her statement WMB.0999.0001.00001 @ p28 para 18.5]. The closure date was flexible because the HHS was going to maintain services for as long as possible until there were

alternatives available [Ms Dwyer XNCA 12-103.23-24]. WMHHS concentrated upon the transition plans for the adolescents that were currently within their care [Ms Dwyer XNCA 12-106.4-5]; and

(b) The approval of the Department or the Minister for Health.

7.36 Neither WMHHS nor WMHHB had the legal authority to 'decide' to close BAC. Neither of them purported to do so, save in respect of the physical act of closing the doors of BAC once all patients had been transitioned or discharged.

7.37 Neither the Board Papers presented by the WMHHS nor the Minutes of the Board reflect a 'decision' to close or a belief by either WMHHS or WMHHB that either entity had the power to do so. Dr Corbett said, "the decision to close the Barrett had actually been made before the Board was implemented in 2012. What the Board were looking at – was the cessation of services around the Barrett. So our assumption and basis was the decision to close had already been made" [Dr Corbett XNCA 9-43.31-34]. "It'd been made before 2012. My understanding is it was made around – sometime around 2008" [Dr Corbett XNCA 9-43.36-37]. "On the basis the decision to close had already been established, the Board were then looking at the timing and the appropriateness of the closure of the facility" [Dr Corbett XNCA 9-44.15-18].

7.38 The Minutes clearly reflect that the involvement of the Department and the Minster were necessary and both were subsequently and appropriately engaged.

7.39 Dr O'Connell said it was inevitable that the BAC closed, it was only a case of when, because of the age of the building,...different financial pressures and a sense that in both national and state mental health plans we needed to move to a more community-based support, never saying that there wouldn't be a need for some patients to be institutionalised for months on end, but saying that, increasingly, we would want to provide support into eh community [Dr O'Connell XNCA 12-22.45 to 12-23.9].

7.40 WMHHB did not endorse a proposal to stop accepting BAC patients (see Board Minutes May 2013 and papers for subsequent meetings), reflecting:

(a) The 24 May 2013 Board decision was not a decision to close BAC, only to support closure.

(b) The Board and WMHHS's understanding that WMHHS was obligated to continue to provide the services unless and until a decision to cease was endorsed by the Department.

(c) There was no decision to cease the service until a decision to do so had been made by the Department and announced by the Minister. WMHHS continued to accept patients until that time.

(d) The Minister's approval was to be sought not to accept any further patients into BAC (page 130 statement of Eltham – Minutes of 24.5.13)

7.41 The Board consistently held the position that any nominated date (for closure, January 2014) was contingent upon the safe and appropriate transition of patients [Dr Corbett XNCA 9-49.15-16]

7.42 The Board became so satisfied over the course of the next six or eight months, through monthly updates on the strategy and the discharge planning [Dr Corbett XNCA 9-49.39-42]. Dr Corbett said "we were assured that there was no gap to service and that appropriate – as they're called here- wraparound services were available" [Dr Corbett XNCA 9-50.3-5] by Ms Kelly and Dwyer and the services were not created in a vacuum only by WMHHS but there were strong liaison and links with MHAODB, with the Department of Health and with Children's Health and Hospital Service too. [Dr Corbett XNCA 9-50.15-19].

7.43 Without the approval of the Department and the endorsement of such approval by the Minister, BAC would not and could not have been closed.

7.44 As to the development of alternative service options:

(a) There was clear recognition that the development of alternative service options was not within the bailiwick of WMHHS (it was not within the responsibility of the Board... it was a State-wide responsibility [Mr Eltham XNCA 9-9.33]).

(b) It was recognised that the appropriate agency to have governance over this process was CHQHHS and that MHAODB was the agency and relevant approver with respect to funding for options developed. Children's Health Queensland had a facilitating role in developing alternative models of care for the patients of BAC throughout Queensland. However, it was the case that the development of alternative models of care for patients was actually for all child and youth throughout Queensland and not just confined to those young people who where transitioning form BAC and Children's Health Queensland had a responsibility for paediatric services throughout the State [Dr O'Connell XNCA 12-26.35-40].

7.45 As a consequence:

(a) Statewide Adolescent Extended Treatment and Rehabilitation Initiative SWAERTI (later AMHETI) was constituted, under the auspices of CHQHHS with the responsibility of developing Statewide alternative service options, led by CHQHHS. The responsibility for developing the services was with the Children's Hospital and Health Service Board (and through the Chair to the Minister) [Mr Maynard XNCA 12-73.15-23].

(b) WMHHS held responsibility for the management and transitioning of existing BAC patients.

7.46 In July 2013, WMHHS received assurances from Dr Kingswell that a Y-PARC would be operational by December 2013/January 2014. The work being undertaken by SWAERTI, in particular Dr Stathis, included considering modifications to the Y-PARC to suit the service needs in Queensland. Had that occurred, the ECRG's recommendation of a T3 service would have been met, with timing co-inciding with the target closure date for BAC.

7.47 On 6 August 2013, the Minister announced closure of BAC, that new service options would be developed and the likely timing of closure was early 2014. This was consistent with the advice being provided to WMHHS regarding a Y-PARC being on line by December 2013/January 2014.

7.48 A target of closure of BAC at around December 2013/January 2014 was reasonable given:

(a) The age of the existing BAC patients.

(b) The number of BAC patients already in discharge planning processes. The majority of the inpatients at BAC were, as at the Board meeting of 24 May 2013, turning 18 in the coming six months [Ms Kelly XN McMillan QC 11-99.10 & 38-40]. As at 14 October 2013 Dr Brennan advised Ms Kelly that there were patients and Dr Geppert advised her that there were by mid November 2013 [Ms Kelly XN McMillan QC 11-100.2-6].

(c) The advice that a Y-PARC would be on line by that time. Ms Kelly said that she understood from Dr Kingswell that the Y-PARC model could be tendered for and put in place by January 2014 and that a Y-PARC would then be developed in the north of the State in the future [Ms Kelly XN McMillan QC 11-98.5-10] and a residential rehab service was discussed in July 2013 [Ms Kelly XN McMillan QC 11-98.28-30]. Y-PARC guaranteed the service would accept referrals in alignment with the closure plans for BAC December/January 2013/2014 [Ms Dwyer XN McMillan QC 12-129.18-48].

(d) There were in fact a range of services established during this period including those in the non-government sector, there was a residential service that opened at Greenslopes, the extending of the acute service in Townsville with a Step Down and community based support program and there was the development of an Outreach model as well [Ms Dwyer XN McMillan QC 12-131.6-14].

(e) General knowledge within the sector that a six month timeframe for transition is adequate, including for complex/long stay patients Prof McDermott said:

> *"the most important thing that I suggest about transition is time, and I would have thought a frame form the announcement of the closure to transition of about 6 months would have been very – well, would have been adequate. During this time you could have achieved 2 things. You could have potentially discharged those who would have been within the six month period. So their care experience would have been unchanged. But for more complex people, you could have, if you like, interdigitated with a service that was to take up that person and you could have a period shared care, and is – relationships established with the next therapy team prior to leaving the first place of care. So that's a fairly – fairly established principle". [Prof McDermott XN CA 7-42.40 to 7-43.2]*

7.49 Once closure is announced and transition processes commence, there are risks in not implementing within a relative closed period:

(a) Continued uncertainty is not therapeutically beneficial to patients - nor is readmission which as Professor Kotze made clear carries risks of "attaching, detaching" for adolescents.

(b) As less complex patients are discharged, it becomes increasingly unsafe and contrary to the therapeutic interests of the remaining patients welfare to remain in the unit.

(c) With a small number in a unit, it is not viable to 'cease' the process of closure. For particular patients it becomes less safe to stay than to go, even if the receiving service is somewhere which may be considered to be a less supported environment.

7.50 The closure date was always flexible in that:

(a) WMHHS and WMHHB had committed that BAC would not close unless and until all patients were successfully transitioned. The date for closure being dependant upon all patients having appropriate transition plans in place and continuity of service delivery [Mr Eltham, XN O'Sullivan 9-22.48 to 9-23.3].

(b) Staffing and other arrangements were such that care could continue to be provided as long as patients remained.

7.51 WMHHB sought and obtained reports as to the progress of transitions on a monthly basis.

7.52 The first advice that alternative services would not be on line by the end of 2013/early 2014 came in or around November 2013. By that time:

(a) A number of patients had transitioned or were on a trajectory for imminent discharge. Whilst there had been some flexibility with the closure date, the date for closure became less flexible as it approached as with a small number of patients the issue of their safety arose in a large ward on their own [Ms Kelly XNCA 11-39.21-24].

(b) EFTRU was operational, although a deliberate decision had been made to limit numbers and apply very conservative risk assessment to the initial cohort because of concerns

regarding risk to BAC patients (and despite those, a 'no ground leave' policy had been imposed on the BAC patients to further manage risk).

(c) There was clear evidence that uncertainty about the future was having a potentially adverse effect on patients and staff eg., loss of BAC nursing staff who, in anticipation of the closure of BAC found other employment [Ms Kelly XNCA 11-38. 26-30]. There were continuing issues around being able to staff the Barrett appropriately [Ms Dwyer XN O'Sullivan 12-126.29-30]

(d) It was not viable to halt the transition process at that point in time.

7.53 There was no clinical reason to halt the transition process. Clinical decision making was that remaining patients could be transferred safety and that remaining at BAC was not therapeutically appropriate.

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[41] First statement
[42] T20-91-91.

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9 Observations on Counsel Assisting's submissions

9.1 The necessity of this section was foreshadowed at the commencement of these submissions. Given the quantity and content of Counsel Assisting's submissions some observations should be made.

9.2 It appears well settled that the role of Counsel Assisting this Commission is not to appear as advocate arguing for a particular result. The Commissioner is enjoined to with conduct an open and "independent" inquiry (*Commissions of Inquiry Order (No 4) 2015*, para 3). The role of Counsel Assisting is to "assist" the Commissioner (*Commissions of Inquiry Act 1950* (Qld), s 21). Counsel Assisting must, like the Commissioner, therefore at all times remain independent and impartial.

9.3 Axiomatically, if the conduct of Counsel assisting appeared to be partial:

- "*And if the Commissioner appeared to condone that conduct, then the hypothetical observer might reasonably apprehend partiality on the part of the Commissioner.*
- *So for example, if the conduct of Counsel assisting showed an evident and persisting inequality of treatment as between witnesses espousing one view of matters under enquiry and witnesses espousing on* [sic] *opposing view, if one group of witnesses was apparently*

frustrated in its attempts, and if a Commissioner either gave support or took no action to redress the situation which unfolded before him, it would not be wrong to consider that such support or inaction in allegation apprehended bias on the Commissioner's part was raised by an individual whose conduct was under scrutiny."

- *Firman v Lasry* (2000) VSC 240 – as Dunning SC[43] stated, whilst the rules of evidence are not required to be observed nonetheless it does not automatically mean that it is desirable that they be ignored.

"*It is to be remembered that rules of evidence have developed not to make the resolution of factual controversies more difficult or less likely, but rather to promote the quality of the evidence upon which such findings are made by the objectives of fairness in ascertaining the truth through accurate fact finding.*"[44]

9.4 That Counsel Assisting provides submissions is uncontroversial and clearly should assist the Commissioner in addressing the Terms of Reference in the manner proscribed and assessment of the relevant evidence before it.

"*It has been stated that in relation to final or closing submissions, it is the function of counsel assisting to:*

- *Provide notice to all persons who might be adversely affected (whether or not they have been granted authorisation to appear and be represented) of possible adverse findings;*
- *Make final submissions as to :*
  - *The possible findings of fact that could be made by the commission including references to the <u>evidence that support such findings and references to contrary evidence ;</u>*
  - *<u>The possible findings that should be drawn having regards to the terms of reference</u>.*"[45] *(emphasis added)*

9.5 It has been also said[46]

"*The submissions also give the Tribunal a helpful and, it is hoped, objective view of the findings that might be made. In this respect the submissions from Counsel assisting should be different in kind from those presented by parties in an adversarial proceeding, in the sense that they should not seek to advance particular cause or case but instead seek to fairly and objectively analyse the material that has been produced before the Tribunal.*"[47]

And further:

"*Efficiency would be promoted in such a case because Counsel assisting would have the advantage of adopting an impartial and objective approach, rather than the partisan approach of attempting to uphold the government decision or advance the government position.*"

9.6 The submissions achieve none of the above and further:

[43] Role of Counsel in Commissions and Inquiries

[45] "The role of counsel assisting in commissions of inquiry"-Justice Peter Hall – Bar News 2005 citing *Royal Commission into the Building and Construction Industry,Vol2 , Conduct of the Commission – principles and procedures(February 2003) para 39 at p55*

[46] Wayne Martin QC (as he then was) conducting an enquiry [2004] Admin Review 2004; (2004) 56 Admin Review 16

[47] At p.10

(a) Do not address and explore the Terms of Reference.

(b) Use language which is replete with subjective and pejorative comments in relation to witnesses.

(c) Assertions are made which reflected their perspective in cross-examination.

9.7 It is apparent on a reading of the submissions that there is no apparent and obvious attempt to provide a thorough exposition of the terms of reference.

9.8 In fact, by adopting an unusual approach of setting forth 4 fundamental issues, Counsel Assisting have fallen into error and led themselves into answering questions which do not directly correspond to the terms of reference. Hence, an example of this is the question posed, how was it at 2014 that where there is no extended treatment facility available to young people before January 2014 who would have been treated by the BAC.[48]

9.9 There is no analysis of one of the major issues involved in the decision to close BAC which was that it no longer provided a contemporary model of care. What has occurred in the submissions is effectively a reverse engineering of considering and rejecting various expert views as to there being an extended treatment facility rather than the evolution of expert psychiatric opinion as to the appropriate care for the group of adolescents.

9.10 In fact, there is no real dissection of the cohort of BAC patients which one would have thought was a necessary preliminary question to be posed.

Language utilised by Counsel Assisting

9.11 In an unusual manner which demonstrates partiality on the part of Counsel Assisting, the submissions are replete which range from subjective to outright pejorative and intemperate language. The following are just some examples:

(a) Para 120 “that decision was made in a fragmented way with no proper analysis, and for disparate reasons based on unsafe factual foundations”.

(b) Para 121 “Unfortunately , to understand the legal basis…. It is necessary to explain.. the scheme of the Hospital and Health Act”.

(c) Para 64 of Dr Stathis “However, perhaps because of his somewhat antagonistic attitude”.

(d) Para 192(c) “this theory is raised as a slogan”.

(e) Para 194 “it is odd to use that draft as evidence..”

(f) Para 215 “Another curiosity is …”

(g) Para 216 “in the circumstances, the Board’s decision to proceed with the closure is inexplicable. Also inexplicable is apparent lack of scrutiny or debate.

(h) Para 220 “Mr Eltham and Dr Corbett gave vague responses”,

(i) Para 232 “This plan to develop alternatives lack any real conviction”. Indeed Dr Corbett and Mr Eltham were content with superficial assurances..’ aggravated by these not having been put.

[48] See paragraph 117

(j) Of Mr Springborg's decision para 249 "again the reliance on unidentifiable conversations – probably informal … There was apparently no thought .."

(k) Para 250 "It is extraordinary that at least part of that re-allocation".

(l) Para 251.."that is an unsound basis for a decision involving this much public money .." aggravated by that not being put.

(m) Para 261 "In short, the Board's decision is a superficial one – probably based on the presentation of Ms Kelly or Ms Dwyer and on an agenda paper which was inaccurate or misleading " again this wasn't put to either.

(n) "Understanding the lingo"

(o) Para 294 "are littered throughout the evidence"

(p) Para 581 "However, by good fortune and surprise, it appeared that condition improved".

9.12 The difficulty is that, given their prevalence and distribution throughout the submissions it demonstrates that there has not been the impartial and non-adversarial approach by counsel which is enjoined by commentators and authorities.

Assertions which are made reflecting the perspective in cross-examination

9.13 It is notable that at para 15, Counsel Assisting cite the additional weight that should be accorded to Dr Scott and Professor Hazel's opinions. They omit Professor McDermott, Dr Stathis, Dr Hoehn, Dr Brennan, Professor Kotze and Dr Sadler, who clearly possess significant relevant experience.

9.14 It is particularly unfortunate as the consequential evaluation of their evidence is indicative of the approach adopted in cross-examination with those and other witnesses. An illustration is if one compares the open questions posed to witnesses such as Dr Scott, Dr Sadler and Dr Breakey with the closed and at times aggressive cross-examination of Dr Stathis and members of WMHHB and executive of WMHHS .It is apparent the differentiation in treatment.

9.15 This was made explicit in the following exchange by Mr O'Sullivan:

> "*The witness is trying to give some evidence, and instead we get this attempt to provide what appears to be a narrative that suits Counsel Assisting. The witness is trying to give some examples as to what she means by something very important to your Honour, which is whether there was a tier 3 available 5 in January 2014, and she hasn't been allowed to provide the evidence. We object to that*." 19/02/2016 objection of Unidentified Speaker during examination of Leanne Geppert by Mr Freeburn. 10-27:1-6

9.16 The suggestion of the "narrative" is exemplified by:

(a) The manner in which Professor McGorry was briefed. There were no questions annexed to his statement form the Commission as one would expect nor a list of materials provided nor what information he was provided by them. He saw the statement of Dr Sadler and a draft model for "Redlands" without any further detail. Yet he expressed opinion of irresponsible de-institutionalistaion without being advised of any specifics of same and that is quoted verbatim in the submissions.

(b) Further when Professor McDermott was critical of the research on fundamental methodology issues of another Barrett advocate , Dr Ward, Counsel assisting did not

explore that further but left it. This is a glaring omission given the prominence of his evidence and reliance placed upon it.

(c) Furthermore, there are a number of examples whereby partiality was shown in cross-examination such as with Dr Groves where Counsel assisting sought to adduce from him on what terms he left the employ of Qld Health. When objection was taken, Counsel assisting was unable to advance any argument as to why such a question would be relevant. The only inference that can be drawn was that it was either a slur upon the witness or upon his then employer, Qld Health.

(d) An example is in the cross-examination when challenge was taken in relation to questions asked by Counsel assisting as to the f Dr Sadler. Counsel assisting sought to justify their questions on the basis that it was a "*suggestion*" that was open to the Commissioner to find that there was, in effect, an ulterior motive to the of Dr Sadler. That line of questions was disallowed by the Commissioner.

(e) Furthermore, cross-examination for instance of witnesses such as Dr Corbett was posited on the basis of very limited sentences or excerpts from board agenda papers and minutes which were quite misleading.

(f) Witnesses such as Dr Geppert were cut off in the giving of answers to counsel assisting, but contrast this with the expansive style toward other witnesses.

(g) Contrast that with Counsel Assisting's conduct in the taking of Dr Scott's statement whereby emails that were clearly disclosed in relation to Dr Scott's adoption of the ECRG process were not annexed to his affidavit nor corrected in chief. They place a completely different complexion on his evidence and the weight which may be accorded to his evidence.

(h) It is therefore unfortunate at the very least that the Commissioner will gain little or no assistance from those submissions, but in fact may lead herself into error by relying on them as providing assistance as to the evaluation of evidence and therefore consequent findings that may be made.

9.17 Issues with respect to matters not being put to witnesses yet being the subject of submissions was raised with Counsel Assisting. **Annexure B** is a copy of Corrs' letter to Counsel Assisting dated 21 March 2016 and Counsel Assisting's response dated 22 March 2016.

Counsel for WMHHS and WMHHB

Barrett Adolescent Centre Commission of Inquiry

Submissions on behalf of the West Moreton Hospital and Health Service and the West Moreton Hospital and Health Board

Part 2 – Terms of Reference 3(d) – 3(i)

Contents

TOR3(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*):

1. Who are the transition clients?

1. As Counsel Assisting had pointed out, the language requires some association between the particular patients transitioned from BAC to alternative care arrangements and the closure, or anticipated closure, of Barrett.

2. Logically, this language excludes patients who were discharged, or prepared for discharge, in the ordinary course of treatment at Barrett.

3. As put by Senior Counsel Assisting to Vanessa Clayworth, and as explained by her:

> "But those – they were discharged because they got well enough, effectively, to go somewhere else? --- Yes. And part of their discharge in planning had – for some of them had already commenced before the announcement of the closure.
>
> Right. Now, transitioning ---? --- Yes.
>
> --- So the transitioning that was required by the anticipated closure of the centre is an entirely different process? --- It has some of the same elements, but it – yes, it was different.
>
> And the difference - … --- If Barrett was to continue there would not have been discharge from Barrett at that time."[1]

1 22-51.35 to 22-52.2.

4. Of the patients identified in the "Confidential Working Draft (Potential Transition Client List, "the Working Draft")) the following patients were excluded during the course of oral testimony:

(1)

(2)

5. This leaves the following core clients within the potential "transition client" cohort, namely:

6. Before considering the individual cases (and TOR3(d)(i) and (ii), 3(e) and 3(f)) it is apt to consider "transition" in the current context.

2 20-60.30.
3 See at 22-63.36.
4 See at 20-35.5 to 10, 20-36.30 to 45, and 20-73.25 to 45.
5 Drs Sadler, Brennan and Ms Clayworth – see Footnote 535 of the submission of Counsel Assisting.
6 At 20-35.5 to 10 and 20-36.30 to 45, Dr Brennan identified of this cohort of o be "transition clients". The exception was who she did not name. It is assumed this was an oversight, being otherwise a clear candidate for inclusion as a "transition client".

2. What is meant by "transition"?

7. Counsel Assisting cite *Blum, et al*[7] who define "transition" as "the purposeful, planned movement of adolescents and young adults with chronic physical and medical conditions from child-centred to adult-oriented health care systems".

8. From the literature, other definitions are available, including:

> "Health care transition has been described as 'a purposeful, planned process that addresses the medical, psychosocial, and educational/vocational needs of adolescents and young adults with chronic physical and medical conditions as they move from child-centred to adult-oriented health care systems'. It may be one of a number of developmental transitions that young people face as they move through adolescence into adulthood. Health care transition planning and management are key elements in the organisation and delivery of health services. Transition is particularly important between child and adolescent mental health services (CAMHS) and adult mental health services (AMHS), because failure results in service delivery being weak when the needs of young people are most pressing … Transfer is often discussed as a suboptimal version of transition but, in our hypothesis, it is distinct from transition and should be investigated alongside transition. Transfer is the termination of care by a children's health care provider and its re-establishment with an adult provider, i.e. more of an event or transaction between services. Transition is a process requiring therapeutic intent, which may be expressed by the young person's preparation for transition, a period of handover or joint care, transition planning meetings (involving the young person and carer, and key CAMHS and AMHS professionals) and transfer of case notes or information summaries. Transition ultimately results in established engagement of the young person with adult services and therefore includes vital aspects of continuity of care".[8]

9. In the Queensland Government Department of Health Guideline: "Guideline for the Transition of Care for Young People receiving Mental Health Services" (No 1, effective from: 21 September 2015)[9] "transition" is defined[10] to be "the process and period of changing care arrangements for a young person" whereas "transfer"[11] means "the act of moving the young person from one care facility to another, or to another care arrangement".

10. In her testimony[12] Dr Brennan provided her interpretation of both concepts:

> "--- I think transfer is a little bit like discharge and then arriving at another service. It's just a point in time. In my view, transition is a process which should start early - … but it starts early, it is individualised, if you like, patient-centred … but it is centred on the patient, it involves their wishes and their best interests. It involves looking at a range of options, seeking to identify those they are happy with and that are appropriate for their needs, communicating with those services, and then providing some kind of transition process where there is a gradual introduction to that service. And depending on the particular person, their particular, if you like, disorder and their range of family or community supports, that transitioning into a new service may need to be gradual in terms of a kind of cross-tapering of care or it may be different. There may be some in-reach into the new service. But overall, I view transition as a process rather than just a change at a point in time. And in terms of when it should start, I guess I had done – I had an interest, actually, in transition of adolescent to adult health care prior to ever going to Barrett, and I think it varies enormously, depending on the particular conditions. However, I think the guidelines around transition for adolescents or children to adolescent to adult services indicate that it really does need to start either at the point of

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7 Blum, Garrell, Hodgman and Slap (1993), as outlined in their *Transition to Adult Health Care for Adolescents and Young Adults which Chronic Conditions Position Paper.*

8 *Transfers and Transitions between Child and Adult Mental Health Services* by Paul and others, the British Journal of Psychiatry (2013) 202, s36 – s40: COI.012.001.0365 at s36.

9 COI.012.001.0523.

10 At 7. on page 7.

11 Again, at 7. on page 7.

12 At 20-16.20 to 40.

admission into whatever service they're going to be leaving or very soon afterwards, and it certainly would need to have been in place, I think, for some months …".

11. Vanessa Clayworth testified as follows:

> "I actually divide the young people at Barrett into three different categories. There's young people that are discharged in the normal process of care according to their clinical needs and where they are in their recovery. There's young people that have transferred to another service in regards to that acuity and risk. And then there's young people that were transitioned. I would describe the first group as *discharge*, not *transition*. I think a transition is part of what we did in the process when the young person would not have been transferred from Barrett in their normal course of care, they were only transitioned out due to closure.
>
> I have patients that I would put as *discharge*, and they were discharged because they were well enough to go somewhere else and part of their discharge planning (for some of them) had already commenced before the closure announcement. So the transitioning required by the anticipated closure is an entirely different process, it has some of the same elements, but it was different." (22-51.10-40).

12. Other authors have identified particular features of transition, including that transition is "complex" (Cutler and Brodie, 2005) and that it is a guided educational and therapeutic process, not simply an administrative event (Viner, 2001: Remorino and Taylor, 2006).

13. Blum, et al (2002) identified the goal of transition, rather than defining it, to be:

> "The goal [of transition] is to maximise lifelong functioning and potential through the provision of high quality, developmentally appropriate health care services that continue uninterrupted as the individual moves from adolescents to adulthood".

14. Other matters of note in the literature include:

> "A transition plan needs to be tailored to the individual, incorporating a holistic approach that takes into account the medical and psychosocial needs of the individual. Special consideration should be given to adolescents with cognitive or developmental delays.[13]

15. In its 2014 publication,[14] the New Zealand Ministry of Health noted:

> "Whilst the importance of effective transition planning has been recognised for several decades, no national transition planning guidelines have been developed for … services in New Zealand until now. A 2012 Ministry of Health survey identified that very few … services currently have written policies or tools to guide transition planning within their services. Similarly, a scan of international literature revealed little in the way of structured transition planning guidelines for adult mental health/AOD services and no specific guidelines for ICAMH/AOD services.
>
> The Victorian Government Department of Human Service in Australia has published some papers relating to transition planning for adult mental health services and protocols for the interface between specialist mental health services and primary level services (Mental Health Branch, 2005a, 2005b; Office of the Chief Psychiatrist, 2002), and these guidelines have drawn on the content of those publications".

TOR3(d)(i) and 3(d)(ii)

16. Following identification of precisely who the "transition clients" are, **TOR3(d)(i)** requires an assessment of their "transition arrangements", specifically:

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13 Gilliam and others (2011), referenced at "Key Principles for Transition of Young People from Paediatric to Adult Health Care: Agency for Clinical Innovation and Trapeze, the Sydney Children's Hospital Network 2014: CO1.012.001.0405, at p. 15.

14 Transition Planning Guidelines for Infant, Child and Adolescent Mental Health/Alcohol and other Drugs Services, Ministry of Health, New Zealand, May 2014: CO1.012.001.0433, at p. 5.

(i) how care, support, service quality and safety risks were identified, assessed, planned for, managed and implemented before and after the closure ("transition arrangements");

17. Following enquiry into the "transition arrangements" themselves, **TOR3(d)(ii)** mandates a quantitative assessment as to:

(ii) the adequacy of the transition arrangements;

18. "Adequacy" appears in TOR3(d)(ii), and also in TOR3(e) (which requires enquiry directed to "the adequacy of the care, support and services that were provided to transition clients and their families") and again at TOR3(f) (directing enquiry into "the adequacy of support to BAC staff in relation to the closure and transitioning arrangements for transition clients").

19. As for all parts of the TOR, proper attention must be paid to the choice of language.

20. In ordinary usage "adequate" means "equal to the requirement or occasion; fully sufficient, suitable, or fit"[15] or "sufficient, satisfactory".[16]

21. "Satisfactory" means "adequate; causing or giving satisfaction; satisfying expectations or needs; leaving no room for complaint", and "sufficient" means "sufficing, adequate, enough".

22. The Macquarie definition is noteworthy because it requires an evaluation by reference to the "requirement" or "occasion". This focuses the assessment not only with reference to the transition client requirements, but also (with reference to the "occasion") by considering contemporary service availability, and the contemporary factual mix.

3. The Kotze:Skippen Report

23. A factual enquiry identical, or near-identical, to that mandated under TOR3(d)(i) and (ii) and 3(e) was authorised under Terms of Reference giving rise to the so-called Kotze:Skippen Report dated 30 October, 2014.

24. Pursuant to Terms of Reference authorised by the then Director-General Queensland Health (Mr Ian Maynard) the Report authors were appointed to:

(1) assess the governance model put in place within Queensland Health (including Department of Health and West Moreton, Metro South, and CHQ and any other relevant HHS) to manage and oversight the health care transition plans for the then current inpatients and day patients of BAC post-6 August, 2013 until closure in January, 2014, and:

(a) advise if the governance model was appropriate given the scope of the work required for the successful transition of the then patients to a community-based model;

(b) advise if the health care transition plans developed for individual patients by the transition team were adequate to meet the needs of the patients and their families;

(c) advise if the health care transition plans developed for individual patients by the transition team were appropriate and took into consideration patient care, patient support, patient safety, service quality, and advise if these health care transition plans were appropriate to support the then current inpatients and day patients of BAC post-6 August, 2013 until its closure in January, 2014;

(d) based on the information available to clinicians and staff between 6 August, 2013 and closure of BAC in January, 2014, advise if the individual health care transition plans for the then current inpatients and day patients of BAC were appropriate. A

15 Macquarie [Complete Reference].
16 Oxford English Reference Dictionary.

detailed review of the health care transition plans for patients who have been associated with serious adverse events should be undertaken. **[My emphasis in each case]**.

(2) Make findings and recommendations in relation to:

(a) in which the management, administration or delivery of public sector health services, with particular regard to the matters identified in paragraph 1 above, can be maintained and improved; and

(b) any other matter identified during the course of the investigation.

25. As a matter of process, extensive documentation was made available to the investigators, including patient files, policies and miscellaneous. Additional information confirming governance arrangements was provided and included a written statement senior BAC clinician, 13.10.14 (Dr Brennan), and interviews conducted face-to-face over 13 and 14 October, 2014. A response letter from Metro North Hospital HHS 28 October, 2014 was included and the investigators undertook an extensive interrogation of the documentation related to transition planning for the

26. Regarding "limitations" the investigators noted that transition is a process in which the communication and negotiations between referring and receiving services are critical and thus, limited investigations to review of the available documentation and interviews with key clinicians formerly from BAC. Staff of receiving services were not interviewed and limited documentation was available from these services. Education Department staff associated with BAC were also not interviewed. A senior nurse from the transition planning team was identified as having a key role in the transition planning process. She was offered but declined interview. In assessing the impact of this as a limitation to their process, the investigators considered the very large volume of material that was available and the level of confirmation across the material and reconfirmation during multiple interviews: **[Again, my emphasis]**.

> "It is the judgment of the investigators that they were able to build up a relatively complete picture at a relatively high level of certainty in regard to the perspective of the BAC staff on the transition process. The investigators do not regard the lack of an interview with this person as a key limitation in the process."[17]

The Findings

27. The investigators' findings are captured at pages 8 to 12. In summary, the findings are:

(1) The process of transitional planning occurred in an atmosphere of crisis consequent to the announcement of the closure and the of the senior leader of the service in the context of an unrelated matter, with escalation of distress in a number of the adolescents and staff of BAC. There appears to have been a contagion effect of distress and anxiety amongst the adolescents and an increasing incidence on the unit. **However 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.**

(2) The closure date set an artificial/administrative deadline for transition, although all formal communications such as letters to parents and fact sheets/updates suggested that BAC would remain open until all transitions were completed. **Whilst on the one hand there was a relatively long period of approximately five months to develop and enact the transition plans, on the other hand there was a sense of time-pressure for the BAC clinical staff because of the complexity of the planning process.**

17 At page 4.

(3) Transitional care planning was led by a small multi-disciplinary team of clinicians headed by the Acting Clinical Director BAC. Their task was enormous as they were required to review and supervise current care plans, manage incidents and crises, seek out information about service options that many times were not readily available, negotiate referrals, co-ordinate with the education staff and manage communication with patients and their families/carers. **The team was dedicated to these tasks, with the day-to-day supervision of the young people undertaken by the Care Co-ordinators.**

(4) **The process of managing the transition of individual patients was centred on individualised and comprehensive needs assessment (including mental health, health, educational/vocational, and housing/accommodation needs) and care planning, extensive investigation to identify available and suitable services to provide co-ordinated care in community settings, iterative[18] planning and collaboration with consumers and families and carers.**

(5) Regarding the patient cohort, the investigators noted:

(a) the young people were a very complex group with various combinations of developmental trauma, major psychiatric disorder and multiple comorbidities, high and fluctuating risk to self, major and pervasive functional disability, unstable accommodation options, learning disabilities, barriers to education and training, drug and alcohol misuse. In short, this was a cohort in the main characterised by high, complex and enduring clinical and support needs;

(b) organising transitional care for such a complex group would have been a very significant challenge even under ideal conditions. Each very complex young person required high individualised care assessment and planning. These are not the kind of individuals who readily "fit" with service systems because of the scope and intensity of their needs. The model of care in existence at BAC had promoted prolonged inpatient care and the forthcoming closure required the rapid development of care pathways to community care;

(6) The BAC team undertook an exhaustive and meticulous process of clinical review and care planning with each individual young person's best interests at the core of the process. Despite the pressure of a looming deadline, there was evidence that the first and critical emphasis of care was to establish and provide good clinical care, including addressing physical health needs such as blood lithium levels and diet/weight management;

(7) **The process of communication and negotiation between the clinical team and the young person and their family/carers was careful, respectful, timely, and maintained.** As would be expected during a time of heightened emotions and anxiety about the future, there appears to have been some misunderstandings at times along the way, but these appear to have been in each case dealt with promptly and appropriately. The misunderstandings arose, for example, in circumstances of unopened emails by parents/carers or unexpected emerging clinical need requiring immediate action by the BAC clinical team, with communication following as time permitted. There is evidence of parent information sessions, letters to parents, individual email responses to parents, and phone calls to support timely communication. Fact sheets, FAQ sheets, and the Executive Review Committee recommendations were also provided to parents/carers and made publicly available on the WMHHS website;

(8) **The transition plans without exception were thorough and comprehensive. In some instances it was not possible to identify a variety of options for each care domain for each client, but in each case at least one reasonable option was able to be identified matched to a particular care domain. At times there was considerable delay in settling on the final option – but this reflected the considerable work**

[18] Iteration is the act of repeating a process, either to generate an unbounded sequence of outcomes, or with the aim of approaching a desired goal, target or result. Each repetition of the process is called an "iteration", and the results of one iteration are used as the starting point for the next iteration.

involved in identifying a range of suitable options and working through processes of negotiation with receiving agencies;

(9) In a number of instances, the young people had psychiatric disorders that on their own did not cross the threshold to service in the community mental health system. It is noteworthy that there were examples of successful negotiations that led to services accepting the referrals by exception. The investigators did not find any example where it was not possible to organise a reasonable system of care for an individual;

(10) The inevitable challenges arose during this process, such as the changes in established long-term relationships between the clinicians of BAC and the young people; the differences between the culture and approach to care provided in services for adolescents and the culture and approach to care in adult services; the impact of the young person's developmental stage and maturity on their health-seeking attitudes and behaviours; and, adolescents' resistance to transfer from a service where they felt safe and "connected" in a relatively closed environment to a community system of care and, in the case of transfer to an adult system, the different expectations of their maturity and health-seeking behaviour and the different expectations of involvement of their family;

(11) **Whilst there was some drop-out from some aspects of the care organised, the investigators did not identify any examples where a young person was completely lost to care, nor where a core component of care was completely missing**;

(12) There were numerous examples of BAC staff working in a collaborative way with receiving agencies, as evidenced by the number of times young people were escorted to the other agencies, the detailed discussions and documentation in relation to risk management, maintaining contact post-transfer of care, and joint working by staff across the agencies. These activities would be considered best practice in transitional care and in the main appear to have been implemented.

(13)

(14) The investigators confirmed that:

(a) the health care transition plans developed for individual patients by the transition team **were adequate to meet the needs of the patients and their families**;

(b) the transition plans for individual patients were appropriate and took into consideration patient care, patient support, patient safety and service quality;

(c) Further, the investigators commend the work of the transition team for the quality and comprehensiveness of the plans and for their efforts that includes "going the extra mile" to secure the range of services required by the young people;

(d) The investigators confirm that the governance model put in place within Queensland Health to manage the oversight of the health care transition plans was appropriate;

19

20 In the cases of

(e) The governance arrangements supported collaborative clinical decision-making at the local level and provided an appropriate pathway for escalation of clinical and transition planning issues;

(f) Cross-membership of committees was designed to support communication flow and membership was sufficiently senior to facilitate authoritative decision-making and action (e.g. sourcing of brokerage funds and funds for family members to travel to participate in transition planning meetings[21];

(g) Available minutes and agendas of meetings indicate regular frequency of meetings **and the involvement of carers and patients in decision-making**;

(h) The investigators noted that some transitional planning documentation was incomplete/missing and there was a delay in the appointment of a project officer, however, it is the view of the investigators that these were minor issues and did not have a material impact on the planning for, or transition of the patients;

(i) In relation to the time-frames given for the process of transition planning to be developed and enacted, it is noted that the deadline was achieved, albeit with a sense of pressure and urgency for the clinical staff especially towards the end;

(j) **The investigators did not identify, however, an individual case in which more time might have resulted in BAC staff providing a better transition plan or process**.

Recommendation

28. The investigators made a general mental health system recommendation. They observed that transitional mental health care for young people is internationally-recognised as a complex and often difficult process and poor outcomes such as disengagement from care are well documented. The BAC process demonstrates positive learnings in relation to good quality transitional planning. It is recommended that these learnings be considered for distillation into the development of a State policy (that supports mental health transition for vulnerable young people).

The Investigators' Brief

29. It is noted that at Items 102 through 121 of the investigators' brief, the medical records (including CIMHA extracts) of the following BAC consumers were reviewed by the investigators,

30. From Appendix B – Schedule of Interviews – it is noted that the following interviews were conducted on 13 and 14 October, 2014, namely, Megan Hayes (OT, active role in transition planning), Dr Stephen Stathis (Director, CHQ), and Dr Trevor Sadler (BAC Clinical Director until September, 2013).

31. Appendix C to the report is a detailed transition planning evidence checklist for the of greatest interest, namely,

[21] For the grandmother of

32. Appendix C was compiled having regard to transfer of care principles set out in the Queensland Health Procedure, namely Inter-district Transfer of Mental Health Consumers within South Queensland Health Service Districts (Version No. 1.0), by the Division of Mental Health, Darling Downs, West Moreton Health Service District. By reference to this procedure, transition planning was assessed utilising three bases, that is to say:

    (i) completion and transfer of documentation;

    (ii) whether the transition planning reflected evidence of, inter alia, assessment of client future service needs, direct consumer assessment and consultation, review of consumer medical charts, contact with referring agency and local mental health service, clinical need and risk taken into account, length of stay of client was considered, client age was considered, demographics were considered, family engagement considered/contact was made with family; and

    (iii) additional considerations (unrelated to the policy), in particular whether funding was sourced to provide comprehensive care, and whether additional supports were sourced, for example, housing and disability supports.

33. **Without exception, each requirement of this procedure was "ticked" by the investigators indicating compliance on the part of the transition team**.

4. Associate Professor Kotze's Testimony (Day 23)

34. In addition to her comprehensive report, the Commission had the benefit of oral testimony from AP Beth Kotze on Day 23.

35. The key points from Professor Kotze's testimony are:

    (a) Professor Kotze is Director of Mental Health for Children and Young People in the Mental Health and Drug and Alcohol Office of the New South Wales Ministry of Health. She has been a Fellow of the Royal Australian and New Zealand College of Psychiatrists for 28 years, and has over 25 years' experience in child and adolescent psychiatry;

    (b) She has had involvement in development of the draft Mental Health Service Planning Framework. This draft includes a taxonomy for agreed service elements in a comprehensive mental health service system. More than 200 experts from Australia were involved in the development of the framework. In developing the framework there was very detailed consideration of the evidence and also models currently operating in the jurisdictions, including discussion about units in other States. It was during this process (which included looking at what was currently available) that AP Kotze came to hear about BAC and to understand that it was not operating on a contemporary model of care (23-5.15);

    (c) In contrast, the services developed by the SWAETRI (later called AMHETI Steering Committee) do align with best contemporary evidence. These are a comprehensive array of services with the components of a specialist CAMHS and youth mental health service clearly identifiable (23-9.25);

    (d) It is certainly possible and it is desirable in certain circumstances for acute adolescent inpatients to be placed with extended treatment adolescent mental health inpatients in the same ward or unit. It has to be purposefully managed with good operation policies and good clinical leadership "but it's certainly possible and certainly appropriate under certain circumstances" (23-9.45);

    (e) Regarding Dr Sadler's testimony that, given there was a crisis at the time, there should have been a moratorium on either closure or the process of transition, Kotze states:

        "So I think that it would have been – there would have come a point when a stop-start approach to the closure could have potentially actually been actually been actually quite damaging, because it increases the potential for the young person to realise that their evident distress might actually result in a change of direction and

> the likelihood, of course, of that happening again. The other issue … to consider in that is that what we were hearing … was that there was very significant levels of distress for staff and a sense of perhaps some fractures in the usual functioning of the multi-disciplinary team, and in part that was also because there'd been a turnover of staff and the loss of very experienced staff, and certainly shifts were filled, but often with casuals, I think, or not so experienced staff. So I think for me, there was a sense in the process of some of the ways in which the Centre was able to provide therapeutic holding for these young people … It is the skilled interaction and the quality of the therapeutic relationship that may assist them in settling and dealing with their emotions. Some of that was really, perhaps, unravelling. I don't recall anybody actually ever saying the situation was becoming untenable, but I actually think it was probably becoming tenuous. So there probably was a point where – I guess a tipping point, but I can't identify when that specifically was. I think the other issue is, too, you've got young people with significant difficulties in attachment, huge sensitivity to abandonment and that whole kind of thing of giving the message: Okay, detach, start moving on, but then reattach. And so it's just – it's not going to work": (23-16: 10-45).

(f) In a general sense, the process of transition at BAC in 2013 wasn't just a "business-as-usual" transition: (23-20), (35.40):

> "The sense I had was that business-as-usual was not a particularly focussed or purposeful process … Modern practice would be that from the very point of admission you're starting to focus on how well does this young person have to be and what are going to be their care needs when they're discharged? So my sense was there was probably fairly significant periods of drift and then towards the end a focus on transitional care or transfer … So I think it wasn't business-as-usual in terms of the intensity of the process, in terms of the focus required, in terms of the time-frame: (23-20, 40 to 23-21.5). So if I think about the guideline, for example, there is an example in that of its given six months. Now … you will find that figure in the literature but what you'll also find and what clinical experience will tell you is that, actually, its highly individualised and you can actually be very surprised at young people's resilience and their capacity when you perhaps felt that … there's a highly significant therapeutic relationship, it will be difficult for the young person to give up. In fact, they're able to move on in a very healthy way relatively quickly. So, yes, the general principle would be – and what you're trying to send clinicians, is the message to be very thoughtful about how they're undertaking the process, what the response of the young person is. But you also need to bear in mind there's a huge variation and it does need to be individualised (23-21; 25-35)";

(g) In the guideline (QHD.008.004.9683) (I) refer to an ideal period of six months and this is in the guideline. This would take some time to be established for some but for others you can actually be surprised (23-22: 1-15).

(h) "In this circumstance, the pace was generally set because of the date of the closure but within that constraint I really do think that the – the team did attempt to – to take it as much as possible at the young person's pace bearing in mind that, of course, it was a very heightened – so it wasn't – it was an abnormal circumstance, if you like (23-23: 1-10)."

(i) "As far as I know, the dates for discharge transition of the young people themselves was – arose from their individual transition care planning. As far as I know, nobody was instructing the multi-disciplinary team about which kids to go in what order and when (23-23.20)."

36. Regarding [redacted] case, AP Kotze testified:

(a) [redacted]

(b)

(c)

(d)

(e)

(f)

(g)

(h)

(i)

(j)

(k)

period of time. And that included providing to the – the receiving agency … very detailed information about … that and the services that I've referred to and, in fact, they also reviewed the environment … So Barrett had highlighted these issues … It would appear that had agreed to assess the issues. They should have – because it's part of the routine management of risk within mental health service settings … I don't know whether they completed that but I do understand that the modifications were not made but I don't have proof of that … But (Barrett) did. They did identify – so in their very comprehensive approach they actually went to the site and identified from their point-of-view environmental risks. (23-39.45 to 23-40.40).

(l) --- Barrett did follow through with the receiving service. What I don't know is what the response of the receiving service was to – to these issues … (23-41.10).

37. In case, AP Kotze testified:

(a) --- I think that for the transitional plan and the services that were achieved were appropriate to the narrow task of transition … (23-43.17).

(b) --- Well, I think if I understand correctly, it's actually a service --- that organised for accommodation, and I think that was highly appropriate … (23-44.30).

38. Regarding AP Kotze was questioned, and responded:

(a)

Mullins Cross-examination

39. Under cross-examination by Mr Mullins, AP Kotze stated:

(a) … Would you have a contingency plan if a transition failed? --- In my – I mean, do you necessarily, in every circumstance, have a plan B? No, you don't. And that's just the practicality of the availability of services and the complexity of some of these patients. And in general, the way you'd be think is … making a judgment yourself about whether you need a plan B, and if you need one, you think you need one, you'd better have one … I think that the usual practice is that on discharge from an inpatient unit – inpatient units don't routinely follow-up the care of people transferred to the community. That is generally seen as a community responsibility. And this circumstance was unusual in that respect, in that they are actually transitioning from – from – from Barrett. What they actually did was they actually did themselves, during the course of … the formal employment and winding down to closure of Barrett, there was very significant evidence of the Barrett staff ensuring how the young person was settling in and whether the arrangements were falling into place. And post-the closure, staff initiated themselves personally those phone calls. I think that that was – that was fine … I wouldn't have expected the Barrett staff to set in place a formal evaluation of this as a specific, say, service development project or something like that … (23-47:5-30).

(b) I think that, actually, the process (transition), really, was – began with Dr Brennan's arrival … There were some who were in the process of – of discharge as usual – definitely … (23-48:10-20).

Cross-examination by Ben McMillan

40. Cross-examined by Ben McMillan, AP Kotze testified:

(a) So what we searched for was evidence that the education service providers had input, provided advice in relation to the education component of the ongoing needs … To that extent, did you rely upon what was recorded in the clinical records --- ? --- Definitely. (23-53:30-38).

Cross-examination by Ms Muir

41. Cross-examined by Ms Muir, AP Kotze stated:

> "So I think when you're talking about the Barrett population, yes, some of these options (as developed in the AMHETI suite of services) would have been reasonable, but you're also talking about a population where no one service element in a contemporary system is going to fit because you have particularly difficult and complex patients with a trajectory already in train." (23-55:15-20).

Cross-examination by Ms Wilson QC

42. AP Kotze was questioned, and responded, as follows:

(a) The transition plans were quite bespoke, weren't they for each of the individuals? --- They were, definitely. Definitely, yes.

(b) So addressing each of those individual needs? --- Yes, yes, definitely.

(c) So if the suite of services … if they were all up and running at the time, it would have made no difference to the transition plans because of the bespoke nature that each of these individuals ---? --- Yeah. It might have been more significant when these kids were coming into the system many years ago. (23-56:10-15).

5. What Weight should be afforded AP Kotze's evidence?

43. At paragraph 99 of Discussion Paper No, Counsel Assisting raised four (4) examples by which it was contended that the weight to be afforded the Joint Report was diminished, namely:

(a) the investigations were carried out in a relatively-short time-frame;

(b) only patients were reviewed in detail;

(c) no patients, families or education staff were interviewed; and

(d) no staff from the services that received the transition clients were interviewed.

44. As to these four (4) matters:

(a) the investigators were appointed on 14 August, 2014 and reported on 30 October, 2014. The investigations were thus carried out over a 2½ month period;

(b) whilst a detailed review of the most complex cases was undertaken, extensive documentation was made available to the investigators in and is stated as having been reviewed by the investigators. In excess of 30 volumes of material was read.[22] At all events, for present purposes, the cases which are the subject of residual concern to Counsel Assisting (as expressed at paragraphs 490 to 667 of their submissions), namely, were each the subject of extensive interrogation (including of the CIMHA database) by the reporters, supplemented by their interview of Drs Brennan, Sadler, and the Care Co-ordinators for each of these clients;

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22 See AP Kotze's Affidavit sworn 18 December, 2015, paragraph 62 and also paragraph 66 ("66. The documentation was initially read in hard copy. Firstly, everything that was made available was read.") See also Ms Skippen's Affidavit sworn 13 November, 2015 at paragraph 11(c) ("I recall the quantity of documents which we were required to review consisted of approximately 32 lever arch files.")

(c) as the investigators explain, transition is a process in which communication and negotiations between referring and receiving service is critical. Having considered the very large volume of available material, and the level of confirmation across the material, and reconfirmation during multiple interviews, the investigators judged that they were able to build-up "a relatively complete picture at a relatively high level of certainty" and thus, they did not regard as a "limitation" lack of interview with staff of receiving services, or education staff. As noted, the investigators reviewed the documentary evidence concerning the process of communication and negotiation between the clinical team and the Young Persons and their families and assessed it to be – objectively – "careful, respectful, timely and maintained";

(d) the fourth suggested weakness is dealt with in (c) above. It is clear that, where thought necessary and appropriate, the investigators sought written responses from the receiving HHS, exemplified by the letter from dated 28 October, 2014.

45. Of course, subsequent to publication of Discussion Paper No. 4, AP Kotze did appear in person before the Commission and was subject to cross-examination. It is submitted that her impressive qualifications, long experience (25+ years), and candour in the witness box would allay any, and all, residual concerns.

46. Although accepting that the Commission is not bound by the rules of evidence, it is submitted:

(a) that AP Kotze's report, supplemented by its author's testimony, is fully comprehensible, and unchallenged;

(b) has conclusions which are rationally-based and fully explained by the witness, thereby permitting:

> "The conclusions to be scrutinised, and a judgment made as to its reliability".[23]

47. In summary, the Commission should reject any criticism of AP Kotze and afford full weight to her joint report and her sworn testimony, particularly in the identified cases of residual interest to Counsel Assisting.

6. TOR3(d)(i). How care, support, service and quality and safety risks were identified, assessed, planned for, managed and implemented before and after the closure

48. Based on the evidence, the appropriate findings urged on the Commission on behalf of WMHHS/B are that:

(a) transitional care planning was led by a small multi-disciplinary team of clinicians headed by the Acting Clinical Director BAC, Dr Anne Brennan. The team was required to review and supervise current care plans (co-existing with their responsibilities as transitional care panellists), seek out information about service options, negotiate referrals, co-ordinate with the education staff, and manage communication with patients and their families/carers. The team was dedicated to these tasks, with the day-to-day supervision of the young people undertaken by the Care Co-ordinators[24];

(b) the process of managing the transition of individual patients was centred on individualised and comprehensive needs assessment (including mental health, general health, educational/vocational, and housing/accommodation needs) and care planning, extensive investigation to identify available and suitable services to provide co-ordinated care in community settings, iterative planning, and collaboration with consumers and families and carers;[25]

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23 *Pownall v Conlan Management Pty Ltd* (1995) 12 WAR 370 at 390, applied in *Pollock v Wellington* (1996) 15 WAR 1 at 4; see also *Steffen v Ruban* (1966) 84 WN (Pt 1) NSW 264.

24 The joint report of Kotze – Skippen dated 30 October, 2014 is relied on in each instance.

25 The joint report of Kotze – Skippen dated 30 October, 2014 is relied on in each instance; see also AP Kotze's cross-examination by Ms Wilson QC in which the transition plans were said to be "bespoke", addressing "individual needs".

(c) the BAC team undertook an exhaustive and meticulous process of clinical review and care planning with each individual young person's best interests at the core of the process. In each case, the first and critical emphasis of care was to establish and provide good clinical care, including addressing physical health needs;[26]

(d) the transition plans were thorough and comprehensive and, whilst it was not possible to identify a variety of options for each care domain for each client, in each case at least one (1) reasonable option was able to be identified matched to a particular care domain;[27]

(e) in all cases, a reasonable system of care for each individual was organised;[28]

(f) in no case was any young person completely lost to care, nor was a core component of care completely missing;[29]

(g) there were numerous examples of BAC staff working collaboratively with receiving agencies (escorting young persons to other agencies, detailed discussions and documentation in relation to risk-management, maintaining or attempting to maintain contact post-transfer of care, and joint working by staff across the agencies). These activities exemplify best practice in transitional care;[30]

(h) in a number of instances, brokerage funding was necessary, and secured, in order to facilitate a high quality transition;[31]

(i) there was a relatively long period of approximately five (5) months to develop and enact the transition plans and this was fully utilised because of the complexity of the planning process;[32]

(j) the general atmosphere of urgency (because of the time-frames, complexity, and other matters) contributed to the overall complexity of the situation, but did not detrimentally affect the process of transitional care planning for the patients, and no commentator has identified an individual case in which more time might have resulted in BAC staff providing a better transition plan, or process.[33]

7. The Adequacy of the Transition Arrangements: General Considerations

Testimony of Dr Anne Brennan

49. Dr Brennan gave broad-ranging testimony of relevance and, we submit, utmost credibility and reliability bearing on the transition process generally at BAC during her tenure, as follows:

(a) "The picture created in the meeting with the Executive on that first morning was of a unit where there was a pattern of episodes involving risk to young people that they were concerned about. I didn't get a sense that they needed the unit closed quickly for any reason other than that, but they had conveyed that they had been concerned for quite a period of time and that there had now been an incident that needed to be addressed and – or that had been addressed, and their concerns were of ongoing safety in the unit. But

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26 The joint report of Kotze – Skippen dated 30 October, 2014 is relied on in each instance.
27 The joint report of Kotze – Skippen dated 30 October, 2014 is relied on in each instance.
28 The joint report of Kotze – Skippen dated 30 October, 2014 is relied on in each instance.
29 The joint report of Kotze – Skippen dated 30 October, 2014 is relied on in each instance.
30 The joint report of Kotze – Skippen dated 30 October, 2014 is relied on in each instance.
31 The joint report of Kotze – Skippen dated 30 October, 2014 is relied on in each instance.
32 The joint report of Kotze – Skippen dated 30 October, 2014 is relied on in each instance. The guideline which AP Kotze developed for QH refers to six (6) months from admission to transition. In evidence, AP Kotze described this as "ideal", although likely to be reduced for some cases. Others testified concerning the length of a contemporary stay for a non-acute medium stay unit. For example, Dr Brennan opined that "a three to six month term" was to be anticipated and Professor McDermott agreed with this. Dr Stedman suggested that "five or six months should be reasonable".
33 The joint report of Kotze – Skippen dated 30 October, 2014 is relied on in each instance.

they did assure me that it was – and in subsequent sessions – that it was to be done with patient welfare considered." (20-7.45 to 20-8.5).

(b) The work that I undertook at Barrett in September, 2013 to January, 2014 … "for most was a transition and for a few, at least one, but a few – was more like a transfer". (20-17.10).

(c) In the particular case of closing the Barrett Centre, I think that if there had been a shared narrative about why is Barrett closing it may have helped. It may have allayed some anxiety for some if there had been a clear understanding of when new services would come on-line and what would they be … I think the perception that services weren't available was highly relevant. Whether those services in fact … whether those services, in fact, would have been appropriate services for particular young people is another issue. But the fact that some, particularly Tier 3, were seen not to be available, I think contributed to the perception of abandonment and I think that made the transition process very complex in this particular case. (20-18.1-12).

(d) I do not think it is correct that most of the patients admitted to Barrett were young people with severe and persistent mental health problems with associated comorbidities, etc. I think that is a description of several. I think there are several who in the past may have met that description but they had had long-term treatment and were doing quite well and so the domains of morbidity for them were much more confined. They were quite functional in many aspects of their lives and so that description wouldn't have fitted them. (20-20.15-20).

(e) I knew that replacement services were still being developed when I was transitioning patients from Barrett. I was aware they were being developed and were not ready for this cohort. (20-21.1-5). I thought it would be counter-productive for me to be involved in development of the new services, not just because of the workload, but because there was significant distress on the part of several people connected with Barrett and some of the patients and their families about the provision of new services and the delay in providing them, and I thought it best that I not align myself in any way with a process that was causing them distress. Towards the end of December 2013, SWAETRI just started to recruit for the YRRU at Greenslopes (the residential facility) and there were some introductory discussions about that, but otherwise, no, they didn't identify any other services. (20-21.1 to 20).

(f) There was a group of Barrett patients who had markedly improved such that they could be discharged from Barrett in the ordinary course of care and could go to their family home, with follow-up supports from a psychologist or psychiatrist. They fitted that description with the caveat that they had, for some of them, an identity as being part of the Barrett cohort who felt abandoned, and they had endured Dr Sadler's [redacted] They were well and able to return to their families and have outpatient care provided publicly or privately. However, with the passage of time and the events that have occurred, that group may look different now to what they appeared to be then in terms of, if you like, their preparedness for transition. I think that the seed had been sown for them to feel vulnerable in a way that they perhaps didn't need to, and that was by the [redacted] … because of their vulnerability and then those events, they may now seem as if they were not ready for transition then but, in fact, I think they were. (20-22.10-40).

(g) Some (patients) were emotionally and psychologically ready to transition … I think there was a significant amount of work done that … bore fruit in terms of getting some of the young people more ready to transition … this was from when I took on the position and transition actually was on the table, and there were frank discussions with patients about transition, but also addressing their own particular difficulties that made it possible to transition some who initially looked like it would be a very difficult task, given the time-frame. (20-23.10-26).

(h) Given my role as a child and adolescent psychiatrist in Brisbane, I was aware of several services, but I think the services that we found very difficult to identify were accommodation services, and … from my experience particularly in private practice, the

resources in our society for anyone with a mental illness requiring supported accommodation are extremely limited, and the accommodation that is available, in my opinion, is extremely poor. And I think that has been the case for many years, at least since the early 1990s … it was particularly difficult for this cohort, the ones needing accommodation, because of their ages … (20-24.1-12).

(i) Many of the Barrett patients are able to be treated with the services currently available, such as CYMHS and AMYOS day programmes, and treatment in acute beds in local hospitals. But some will require a medium term residential facility which provides not only nursing observation and attention to reduction or prevention of self-harm but also educational and vocational training and socialisation. There are such services. I am not familiar with them. I know the names of them. I have not visited them. (20-24.15-25).

(j) I don't believe there is any medium stay facility. I have subsequently become aware from discussions with Dr Stathis that there are sub-acute beds available at LCCH. I am not aware that there is any facility that is focussing on vocational, educational issues with a recovery focus. Now that may be part of the Tier 3 service being developed, but I'm not aware – I don't have intimate knowledge of that service. (20-24.30-35).

(k) My view is that there are some young people who require a medium term residential facility. I think it is beyond the area of my expertise to estimate the number … "But I hope it's not huge. It should be a small number". (20-24.40-5).

(l) Acute units aim for a length of stay of about two weeks. I think it often blows out beyond that. But a medium stay it would be somewhere between perhaps three/four weeks and up to a number of months. I would be aiming for three months which generally is a school term, but realising that people don't always get sick on the last day of the holidays, so therefore, three months is a bit arbitrary. I would think a three to six month term. (20-33.35.40).

(m)

(n) I would say that for some people they identify as a vulnerable abandoned group has been reinforced by events that have happened, and the response to those events by multiple different sectors since their discharge from Barrett. However, at the time of discharging them I felt that this small group that their transition plans were safe and complete and not necessarily rushed. So in terms of timing … four months ought to have been an adequate time to transition them out. I think they would have been left with an abiding feeling of disquiet, discontent, about some of the things that had occurred, particularly Dr Sadler's leaving. And I don't think that staying on at Barrett longer would have provided the opportunity to turn that around. So I don't think the time-frame of closure negatively impacted their transition just from a time perspective. (20-37.15-30).

(o)

(p)

(q)

(r)

(s) I also thought that there was a problem with the time limit of six months. (20-39.20).

Testimony of Vanessa Clayworth

50. Also of relevance in the general context of transition at BAC following the closure announcement was Vanessa Clayworth's testimony as follows:

(a) "The process for transitioning involved clinical care transition panels. These were individual to the patient and scheduled for individual patients. There was a core group of people requested to join the panel but there was opportunity for other staff to join also. After much consideration and many discussions at a time when there was heightened anxiety and the young people were having trouble identifying with somebody they could trust, in order to keep the therapeutic relationship and the therapeutic trust, there was a decision initially that the case co-ordinators would be there to support and advocate for the young people and their families, and not ordinarily be transition panellists." (22-52.20-45).

(b) "The WMS policy document (WMS 0015.0001.00528) I had not seen prior to preparing to give evidence. It could have been used in the transition, but it didn't exist at the time and it certainly wasn't distributed to me." (22-53.35-45).

(c) "I agree with the passage in the document that during periods of transition it can be a risky period handing over to one service from another and especially until the young person has the necessary therapeutic rapport with the receiving service." (22-54.10).

(d) "The document's requirement for a verbal and written communication of critical information passing between the two transitioning entities: … I believe that happens for all consumers." (22-54.25).

(e) "Following my appointment as Acting Nurse Unit Manager, the CIMHA suite of documents came to be used at Barrett." (22-54.30).

(f) "The Acting Nurse Unit Manager is more human resource and operations-related. The Clinical Nurse Consultant is clinical in nature." (22-55.5).

(g)

(h) "I regard [redacted] as being a discharge patient." (22-63.40).

(i) "When I joined the panel there had only been transition arrangements for the people I referred to earlier today in the course of normal discharge planning. I don't believe there had been done much prior to that. Dr Sadler had a lot of hope for the unit and collectively he shared that hope. And I can recall even having a site visit where we went for a site visit to Logan to see if that was an appropriate place where Barrett could be relocated. So in reflection of that, that's an example that Dr Sadler had great hope that Barrett would continue as a service in another location, so no transition plans had yet been actioned at that time." (22-66.35).

(j) "The effects of the non-contact instruction with Dr Sadler were diminished because I had a good understanding of the young people, we still had all their documentation, the young people still had their individual therapist, they still had their case co-ordinators or associate case co-ordinators, information was shared in ICUUs (they're known as care reviews and case conferences), and I made sure I built a sound working relationship with Dr Brennan." (22-67.10).

(k) "I don't believe the project officer, Laura Johnson, captured everything that was discussed in the panel meetings. There was a lot of work required to be done outside of the panels. The panels were allocated a particular amount of time and we still had to run the unit during the normal course of care. We still had to care for the young people so a lot of the work was done outside of the panels." (22-67.40 to 22-68.2).

(l) "It was really difficult to have ongoing monitoring and follow-up after transition when the unit no longer existed and the staff no longer existed as a body. And then the responsibility was, and accountability was, at the receiving service. And Barrett no longer existed and it would have been a breach of our boundaries to follow-up with the young person when we were no longer employed by The Park; and, for example, myself no longer being employed by Queensland Health." (22-70.10-15).

(m) "The case co-ordinators performed a role as a conduit between the transition panel, the young person, and their family. Part of the role of being a case co-ordinator is to have contact with the family. That is one of the primary roles. And often in the care reviews (formerly known as case conferences that were held weekly), in the *Actions* it was listed CC to contact mother, father, carer, whoever it may have been. And the CCs had access to those documents. And on top of that there would be times that I would send emails to CCs asking them to follow-up and make contact with the parents or complete something to assist the transition process, be it referral or a crisis intervention plan … The idea of separateness for them (in relation to transition panel membership) was so they were given information in a form at times that was appropriate to be passed on to the patient and their families." (22-80.20-45).

(n) "Regarding whether Dr Sadler's [redacted] affected the transition process, " --- I think Dr Sadler held a wealth of knowledge and he was containing because he had a relationship with the young people and the family and he had an understanding of the young person's history. But I don't think it would have changed the places that the young people went because it even went above the Clinical Director's role. So be it Dr Sadler or Dr Anne Brennan, it went above their level and did go to D-G Executive, Mental Health Branch level to find these young people placements." (22-81.45).

(o) "When I assumed the Nurse Unit Manager role, I discerned a change towards me from the education staff. I think it was difficult me being in that position because I feel as though I was associated with the theme of the closure. And because I was in meetings and I wasn't able to share information. And the teaching staff at times would ask me that information and it was information that was of a clinical nature and I was unable to share it. And their responses at times I found to be intimidating and body language at times

was aggressive in nature and it – it was unfortunately unpleasant and it hadn't previously been like that … But there were times when the young people wanted to come and speak with me about what the teachers had spoken to them about because the young people were dealing with their own stresses and anxiety and I think sometimes when the teachers were perhaps uncontained with their own emotions, and discuss that with the young people … it was difficult for the young people to process it … They had difficulty with their own emotions, let alone witnessing others and others being put on to them as well … The young people had said they (education staff) were the source of the discussion." (22-83.2-35).

(p) "There was a separation (from education staff) in meetings at times, but I still certainly communicated with education staff at case conference and at the morning meetings." (22-84.20).

51.

52. At pages 22-90.25 onwards the witness rejects assertion that the transition arrangements, process or plans failed to take into account family's wishes.

8. The adequacy of the transition arrangements: the individual cases

53. In the working draft, under the hearing "Issues", the descriptor "no issues" was applied by Counsel Assisting in the following individual cases:

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(2)

(3)

(4)

54. This left a residual number of cases in which "issues" going to, potentially, the adequacy of the transition arrangements were to be explored:

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(2)

(3)

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(6)

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(8)

(9)

55. At paragraph 474 (page 134) of their joint submission, Counsel Assisting state that:

> "... At this point in the submissions, we review the accommodation, clinical care and educational or employment arrangements of those about which there appear to be no significant issues." [my emphasis].

56. Following further review of these cases, Counsel Assisting at paragraph 490 (page 140) state that:

> "490. Although the majority of the transition arrangements appear to be adequate, Dr Brennan raised concerns about patients. These patients are considered in detail below."

What follows (at paragraphs 491 through 677) is a detailed discussion of the cases of residual concern, namely, pages 141 through 152), pages 152 through 165), pages 165 through 181), and (pages 181 through 192).

57. Based on this treatment, it is assumed that Counsel Assisting are submitting for the "adequacy" of the transition arrangements, in all but these identified cases.

58. On this assumption, we proceed to deal with these cases of residual concern.

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(a)

(b)

(c)

(d)

(e)

(f)

64. Concerning case, Dr Brennan testified that:

(a)

(b)

(c)

(d)

(e)

(f)

(g)

(h)

(i)

(j)

(k)

(l)

(m)

(n)

[See also Beth Kotze above].

65.

(a)

(b)

(c)

(d)

(e)

66. Regarding each of the submissions, we respond as follows:

(a)

(b)

(c)

(d)

(e)

(f)

(g)

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71. Potential issues identified for transition arrangements were:

(a) availability and adequacy of alternative services;

(b) suitability of a CCU;

(c) available options to a CCU;

(d) level of supervision required;

(e) level of supervision achieved;

(f) staging of transfer process.

72. Concerning Dr Brennan testified that:

(a)

(b)

(c)

(d)

(e)

(f)

(g)

(h)

(i)

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(q)

(r)

(s)

(t)

(u)

(v)

(w)

73. Concerning case, Vanessa Clayworth testified that:

(a)

(b)

(c)

(d)

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(f)

(g)

(h)

(i)

(j)

(k)

(l)

[See also Beth Kotze above].

74. The conclusions of Counsel Assisting regarding "adequacy" in case appear at paragraphs 624 through 626 of their submission as follows:

"*Conclusion*

624.

625.

626.

75. We respond to these submissions as follows:

(a) We make no submission, except to point out (as was accepted by AP Kotze[34] and by witnesses from PRCCU[35]) that at the point where the supervision was decided to be reduced, PRCCU had assumed clinical governance for care, and the role of BAC as care-giver had ceased.

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80.

81. Regarding ransition, Dr Brennan testified that:

(a)

[34] See at paragraph 36(g) above.

[35] For example, Karen Northcote, the NUM who, at paragraph 8(b) of her statement stated "... Once was admitted at this (that is, developing transition plan and identifying and preparing strategies for care, support, service quality, and safety risks) became the sole responsibility of team

(b)

(c)

(d)

(e) I also thought that there was a problem with the time limit of six months. (20-39.20).

(f)

(g)

[See also Beth Kotze above].

82. At paragraphs 672 through 677, Counsel Assisting conclude as follows regarding transition:

"*Conclusion*

...

674.

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676.

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83. Regarding the submissions, we respond as follows:

(a)

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87.

88. Potential issues regarding the adequacy of transition arrangements were:

(a) suitability of service;

(b) availability and adequacy of alternative services;

(c) restrictions on alternatives.

89. Regarding transition, Dr Brennan testified that:

(a)

(b)

(c)

(d)

(e)

[See also Beth Kotze above].

90. At paragraphs 579 through 581, Counsel Assisting formulate the following conclusions regarding transition:

"579.

580.

581.

91. We respond to these submissions as follows:

(a)

9. TOR3(e). The adequacy of the care, support and services that were provided to transition clients and their families

92. On all of the evidence, the families of transition clients were fully and adequately supported and served, including through open communications. The relevant considerations here are that:

(a) A significant consideration is that it was with the Young People with whom West Moreton was in a clinical, treating relationship, not their families. The purpose of communications with families was to facilitate support of the Young Person by their family (in cases where that was on offer and was otherwise appropriate) and to enable familial support during, and following, transition;

(b) Regrettably, the leaking of the proposed BAC closure during 2012 and the announcement of the closure by the then Minister in August, 2013 gave rise to active opposition to the closure on the part of BAC supporters, including, in part, some families and education providers. Opposition from these groups was maintained in the teeth of

adverse consequences to the mental and physical health of some of the young people at BAC, and others. These circumstances were super-added to pre-existing destabilisation of the BAC unit through the effects of the Redlands' project, and its cancellation (a decision of Government);

(c) West Moreton was not the author of, nor was it responsible for, delays associated with the Redlands Project, and ultimately, its cessation;

(d) Nor was West Moreton responsible for any anxiety caused to families through delay in roll-out of the State-wide model for adolescent mental health (if there was any delay). That responsibility lay squarely with the Mental Health Branch of Queensland Health itself (and/or CH HHS) and West Moreton's ability to communicate to families the progress of that roll-out was limited both by actual progress which those responsible for the roll-out made, and also by what those parties communicated to West Moreton concerning that topic;

(e) Regarding all communications generally, it was important that both the timing, and content, of that information not be the cause of further anxiety and upset to either the Young People and/or their families. This necessitated, for example, circumspection until such time as a workable transition plan had been formulated, and assessed to be reasonable;

(f) The contemporaneous documents in CIMHA plainly evidence that families were fully engaged at critical aspects of the transition process. This is evidenced by the signed acknowledgments from and the annexures to those three (3) documents;

(g) Regarding the transition patient cohort generally, a survey of some of the available documentation listed below confirms close family involvement regarding transition:

Young Person	Event	Reference

Young Person	Event	Reference

Young Person	Event	Reference

Young Person	Event	Reference

(h) It appears that the complaint of some families is not so much with the adequacy of communication but that BAC was to close, at all, or that it was to do so without a "bricks and mortar" equivalent having been constructed. As has been pointed out in the Closure submissions above, none of this was within the remit of West Moreton. In all of the circumstances, we submit for a finding that the care and services provided to the families of transition clients was adequate.

10. TOR3(f). The adequacy of support to BAC staff in relation to the closure and transitioning arrangements for transition clients

93. This is a most complex term of reference and one with which, with great respect, a forum such as this Commission of Inquiry will struggle to resolve. The reason is that the factors at play are highly individual, and multi-faceted. For example, the Commission may take notice that workplace stress frequently occurs even in the best-managed workplaces, particularly so when the content of the work is itself stressful of which work in an adolescent mental health unit must count as an example. So also for a workplace subject to change. Some staff will welcome opportunity for change, others not. Regarding the transition process itself, in the BAC context, most of the work appears to have been undertaken by Dr Brennan and Vanessa Clayworth. As understood from their evidence, although the workload which each of them undertook in that connection was considerable, neither complained of a lack of support from their employer. On the contrary, Dr Brennan testified that any requests she made for assistance were responded to.

94. A real difficulty is that there has been no rigorous, systematic presentation of the evidence relevant to this TOR. A number of the witnesses who advanced criticisms in their statements, retreated in the box. Certainly, the Commission is unassisted by anything approaching expert opinion on the topic, including as to what may, or should, have been done by the employer, over and above what actually was done.

95. Overall, based on a review of the available evidence summarised below, and the cogency of that evidence overall, we submit that no case of "inadequacy" under this head has been made out.

96. Dr Brennan testified that:

> "The nurses themselves told me about their difficulties in coping with their workload as they felt they carried extra responsibility because of the lack of skills of other staff … There were many, many discussions in the first few days and it was clear that the allied health staff and the school staff have been particularly upset by and disappointed by the loss of allied health colleagues who had either not had their contracts renewed or had moved away from the centre … Over the four months, the nursing staff arrangements changed from time to time. For instance, at one point when they realised that the workload for some nursing staff was high, they re-arranged staffing and moved Vanessa Clayworth from her position … I think she was the Acting NUM … and became the Acting CNC. And they brought in Alex Bryce, an experienced senior nurse in The Park … to provide support in terms of supporting the nursing staff, rostering and so forth and was a containing influence on the ward, which was helpful … That happened about early October, I think … As well as that, there were times when nursing staff (I assume casual agency staff) were rostered in Barrett … and our preference in Barrett was that we would have the most familiar experienced staff, the ones experienced with Barrett to be working there. And they would be rostered elsewhere. So when that concern was raised, I was assured that that would continue. And I think those promises were honoured and did happen. Nursing became, in my view, quite critical in about mid-December. And I

alerted those people that you had just listed. And in fact there was a meeting to address those issues in about mid-December, late on a Friday afternoon (so that that guarantee was followed through and I had adequate nursing support) … but I add one more piece to that puzzle … that is that right at the end when the numbers of patients were very small, there was a difficulty … with the gender mix of the patients and the very small numbers made it difficult to roster adequate nursing staff in terms of gender and experience and being able to staff a ward … so when the numbers of patients were very low, and I'm sure there is a formula that prescribes appropriateness in numbers to a particular number of patients, but it became a particularly difficult task to have adequate nursing when the numbers of patients were very low" (see generally 20-12.1-45).

"Many of the nursing and allied health staff had worked at Barrett for a long time and knew the patients well. They expressed to me concern that a move to other and different models of care would impact adversely on patients. I understood their concerns and in about early November I was in Melbourne for a conference and when not there on the ground with the staff I emailed Anne Geppert about my concerns and recall her emailing back that she concurred with my view that this was a vulnerable group of staff and she would discuss this further with HR." (20-14.30-35).

"In the particular case of closing the Barrett Centre, I think that if there had been a shared narrative about why is Barrett closing it may have helped. It may have allayed some anxiety for some if there had been a clear understanding of when new services would come on-line and what would they be … I think the perception that services weren't available was highly relevant. Whether those services in fact … whether those services, in fact, would have been appropriate services for particular young people is another issue. But the fact that some, particularly Tier 3, were seen not to be available, I think contributed to the perception of abandonment and I think that made the transition process very complex in this particular case." (20-18.1-12).

"When I arrived at Barrett, there was an atmosphere of intense distress and uncertainty which was affecting staff morale. It was affecting staff morale badly. The atmosphere was uncontained on arrival. I think there was apprehension and anger. And staff were struggling to cope at that point with what had happened up to there. And then the investigation into Dr Sadler commenced and that involved several of them, and several of the care co-ordinators. And that was very threatening to them, I guess. … Most of the care co-ordinators continued to do an extremely good job. Some took time off work. But I don't recall their absences necessarily had particularly negative impacts because there were other nursing staff at that stage who picked up the slack." (20-68.1-15).

"On every occasion when I did raise a matter of concern – a need which I perceived – with the Executive of West Moreton, it was responded to: I cannot recall one where they didn't." (20-84.30-5).

97. Vanessa Clayworth testified that:

"The announcement of the proposed closure of Barrett did, in her observation, have an effect on staff. Staff were upset about the announcement. There was already some disruption from when it was previously announced that it may have been closing. I was appointed Acting Nurse Unit Manager the day before the announcement of closure was made (my appointment took effect on 5 August and the closure announcement was made on 6 August, 2013). Staff were upset, the young people were upset, the families were upset, I was upset. There were different degrees of anxiety and different degrees of young people, staff and families being upset. --- But I feel as though time went on with the supports that were put in place that it varied and sometimes it was individual-based. --- There were different supports for families. There were different supports for the young people. And there were different supports available for the staff … Post the announcement of closure, I provided debriefing with the nursing staff that were on the shift. I made myself available. I can recall from my notes and an email that I sent to my line manager at the time that I stayed back to, I think, 9.30 at night to be able to support the young people and the staff and be available for the parents to contact on the phone at the time. I offered staff the group debriefing at the time. And ongoing, I offered individual counselling for some of the staff. I also offered staff EAS (employee

assistance) and that was offered in person … So I offered that verbally to them in person. I also offered it in nursing meetings and that's documented in one of my statements … I also sent it on two occasions that I have copies of emails that I did send EAS details to staff. I also provided staff with opportunities on the roster should they need time off to debrief or access clinical supervision. I provided that opportunity for them. I also encouraged them to access clinical supervision. I also appointed associate case co-ordinators to assist the CCs with the care they were delivering to the young people, to share the load … (EAS involves the employee getting time off work to go and talk to a psychologist) … and we also had made it known to staff that EAS would come on-site should they want that in a group setting as well." (22-47.12 to 22-48.24).

"About a month later, Dr Sadler was stood down and that produced more stress on the staff … --- I did offer additional assistance at that time, but the comment that I would like to make to this is that I was instructed that Dr Sadler was on leave … I was under the impression that it was normal leave at that time. I didn't know the circumstances surrounding it … I guess I didn't – hadn't been communicated to me that, possibly, the more sensitive support that may have been required, because at that time I thought he was just on leave and I didn't know how long for … I was instructed that Dr Sadler was on leave by … Padrig McGrath and Will Brennan … (There was then an investigation) … --- … It was – it was very intense and unpleasant for the nursing staff (it produced further stress)." (22-48.10-45).

"I was told that I and the other staff members were not to communicate with Dr Sadler … I can recall that it was in a meeting with Executive that was held with Barrett staff." (22-49.10-15).

"Following my appointment as Acting Nurse Unit Manager, the CIMHA suite of documents came to be used at Barrett." (22-54.30).

"The Acting Nurse Unit Manager is more human resource and operations-related. The Clinical Nurse Consultant is clinical in nature." (22-55.5).

"In August, 2013, there were about 20 or 21 nursing staff on the rosters at Barrett." (22-55.20-5).

"The majority of these would have been permanent staff … --- There certainly without a doubt would have been a majority of nurses that were rostered to Barrett from the rosters. It would either be done by myself when I was Acting Nurse Unit Manager or done by Alex and a skill mix would have always been considered … As the transition progressed, some of the nursing staff found alternative jobs … I think there was a change in nursing staff from when it was announced that Barrett could have been closing – and I'm talking in … November 2012 … There was some change in nursing staff then but my view on that is that it was probably timely for some of those nurses to have moved on at the time and progressed their own professional career and at risk of becoming burnt out. And then that gave an opportunity for other nursing staff to be professionally developed and be supported by West Moreton in progressing their own career. So I think that when other staff did leave, that there certainly was other people that developed professionally and stood up … These nurses were already experienced but they had the opportunity to consolidate their knowledge and – and become true leaders … I do not accept that in that period, from November 2012 onwards, that there was at least some depletion of experienced nurses at the Barrett … I think that the level of knowledge that was still there was a great level of knowledge." (22-56.10-42).

"I felt the need for CIMHA to be utilised in a uniform manner because it was important for risk management and clinical governance as well as sharing of information in continuum of care to receiving services. And I also thought it was important for staff to get used to using CIMHA as when Barrett was closing they may have gone to other health services and would have been required to use it there." (22-76.40).

"The emails I sent to staff to support them are tendered as a bundle and will be marked as an exhibit." (22-77.12).

"My information shared with staff included Fast Facts and communiques. I think the first lot may have been sent by myself to staff and after that, the next lots were sent by Executive. But with each release, I would give the opportunity to discuss them with staff." (22-77.30).

"On becoming the NUM I started a communication folder which was left in the nurses' station and available to all staff. I had in it all relevant emails that I emailed to staff. It also included the Fact Sheets and the communiques. It included any policies and procedures that were reviewed during my time and it included professional development opportunities and information for staff." (22-77.45).

"I was available in the morning handover and the afternoon handover and the evening handover. There were times I stayed back until 10.30 at night. If not, I would email the night staff and let them know that I would come at 6.30 in the morning or 6 o'clock to be available to support them and speak about any concerns they had. I also held clinical nurse meetings. These were meetings with myself and the clinical nurses and were about supporting them in leading the nurses and reviewing any practices or changes that needed to be made to the way the unit is run, and to assist them support the case co-ordinators." (22-78.30).

"If I saw a particular member of the nursing staff distressed I'd provide them an opportunity to speak with me should they want to. And whatever duties they were doing at that time, I would either do them or ask another nurse to do them. But a lot of the time I would do that. So even continuous observations, doing the medication, doing the observations of the young people." (22-80.20).

"From when Alex Bryce took over as NUM it was his role to support the staff. But I certainly still did meet with staff and I encouraged them to meet with HR and discuss their individualised plan for employment." (22-81.25).

"When I assumed the Nurse Unit Manager role, I discerned a change towards me from the education staff. I think it was difficult me being in that position because I feel as though I was associated with the theme of the closure. And because I was in meetings and I wasn't able to share information. And the teaching staff at times would ask me that information and it was information that was of a clinical nature and I was unable to share it. And their responses at times I found to be intimidating and body language at times was aggressive in nature and it – it was unfortunately unpleasant and it hadn't previously been like that … But there were times when the young people wanted to come and speak with me about what the teachers had spoken to them about because the young people were dealing with their own stresses and anxiety and I think sometimes when the teachers were perhaps uncontained with their own emotions, and discuss that with the young people … it was difficult for the young people to process it … They had difficulty with their own emotions, let alone witnessing others and others being put on to them as well … The young people had said they (education staff) were the source of the discussion." (22-83.2-35).

"There was a separation (from education staff) in meetings at times, but I still certainly communicated with education staff at case conference and at the morning meetings." (22-84.20).

98. The document chain for the period from 6 August, 2013 to 14 October, 2013 in which Vanessa Clayworth provided staff with support of various types is summarised as follows:

Date	Event	Reference
6 August, 2013	Ms Clayworth provided staff with support after the announcement that BAC would be closed.	WMS.0023.0003.02961
13 August, 2013	Ms Clayworth emailed staff reminding	WMS.0021.0001.01940

Date	Event	Reference
	them that they could access support through EAS and provided them with details about how to do so.	and WMS.0021.0001.01941
26 August, 2013	Ms Clayworth circulated to staff a copy of Fast Fact 6.	WMS.0023.0001.01002 and WMS.0023.0001.01004
5 September, 2013	Ms Clayworth thanked staff for being supportive of each other.	WMS.5000.0026.00074
5 September, 2013	Ms Clayworth set up a nurses' meeting for 10 September, 2013 in which it was intended that Dr Sadler would discuss the future of Barrett.	WMS.5000.0026.00075
10 September, 2013	The nurses' meeting is held. As a result of the meeting, Ms Clayworth changed nurse rostering so that two CNs would be rostered on Mondays, allowing 1 to attend case conference and the other to be in charge of the shift.	WMS.0018.0001.00394
11 September, 2013	Ms Clayworth sent a detailed update to nursing staff about new staff, Drs Brennan and Hoehn.	WMS.0023.0003.01425 and WMS.0023.0003.01435
13 September, 2013	Ms Clayworth sent around Minutes of nurses' meeting and sets up fortnightly meeting.	WMS.0018.0001.00393 and WMS.0018.0001.00394
27 September, 2013	Ms Clayworth circulated to staff a copy of Fast Fact 7.	WMS.0023.0003.00935
3 October, 2013	Ms Clayworth circulated to staff a copy of Staff Communique 1. Staff were encouraged to raise any questions or concerns with Padraig McGrath and reminded staff that EAS was available to them.	WMS.0011.0001.18412 and WMS.0011.0001.18455
3 October, 2013	Ms Clayworth offered to come in on 4 October, 2013 at 6.30 am to discuss Staff Communique 1 with night staff. Staff were informed that she would co-ordinate times for them to meet with HR.	WMS.0023.0001.01215
10 October, 2013	Ms Clayworth escalated staff questions and concerns about progression of closure to Dr Hoehn, Sharon Kelly, Dr Brennan and Padraig McGrath. She requested additional support for allied health and teaching staff.	WMS.0018.0003.01964

Two Statements of Lorraine Margaret Dowell

99. Ms Dowell's two Affidavits dated, respectively, 27 November, 2015[36] and 2 February, 2016[37] bear, relevantly, on the issue of staff support, specifically to the allied health professionals for whom Ms Dowell was the Operational Line Manager at Barrett between 18 February, 2013 and 2 February, 2014.

100. In her two statements, Ms Dowell states:

(a) In her role as Team Leader/Discipline Senior she met with BAC allied health staff weekly and on other occasions *ad hoc* as required to provide guidance and support to staff specifically in relation to organisational change associated with the potential closure of BAC (original statement 3.3). She also met with staff individually to develop an appreciation of their circumstances and to identify the best way to support them as individuals (original statement 3.4).

(b) Ms Dowell deposes to OPT receipt of information in the form of staff Communiques and Fast Facts sheets (original statement 7.8). She had awareness of 11 Fast Facts information sheets with the last one published on Friday, 20 December, 2013 together with 3 BAC staff Communiques with the last one published on Wednesday, 4 December, 2013. She states:

> "These important documents were routinely circulated to staff (supplementary statement 7.7-9)."

(c) She states that after Dr Sadler was stood down she spent time with the allied health staff encouraging them to provide complete support to Dr Brennan and, in due course, she encouraged the broader allied health team to support the transition work which Dr Brennan and the transition panellists subsequently undertook (original statement 9.5-6).

(d) She states that to discharge her obligation of support to allied health staff during the transition period, she (original statement 10.2) –

(i) held weekly meetings with the allied health staff from 23 September, 2013 until BAC closed;

(ii) implemented a three-phased approach to the work as outlined in paragraph 3.8 of her original statement;

(iii) provided individual support for staff regarding the organisational change process, including advice on strategy to cope with the challenges and stressors associated with each stage of change;

(iv) performed a liaison role between allied health staff at BAC and the human resources team in investigating redeployment and future options for staff;

(v) performed point-of-contact role with allied health staff for formal letters regarding the closure of BAC and available options.

(e) At 10.3 of her original statement, Ms Dowell outlines key challenges for her and other allied health staff at BAC during the time of transition, including:

(i) circulation of constant rumours from various sources including media, teachers, parents and others, many of which were highly inaccurate, but caused uncertainty and staff anxiety;

(ii) the "Save the Barrett" website and other petitions promoted positions which were not aligned with the evidence-based or ECRG approach for considering BAC

36 WMS.9000.0016.00001
37 WMS.9000.0027.00001.

alternatives. Although generally well-intentioned, the positions promoted and their highly emotive nature caused further distress and anxiety for staff;

(iii) some staff were distressed by the [redacted] of Dr Sadler and the investigations which ensued;

(iv) prior to the formal closure announcement, uncertainty as to whether there would or would not be a dedicated inpatient replacement option caused staff anxiety about the availability of an alternative job, and what that might entail;

(v) once the decision to close Barrett was made without a replacement facility being planned, some staff felt the closure decision reflected negative views on their past work and the model of care and/or that adolescent complex care needs were unimportant to the decision-makers and the clinical community;

(vi) maintaining an appropriately-skilled workforce because of staff attrition necessarily following on from the organisational change.

(f) It is Ms Dowell's belief that staff support was adequate. This included industrial support as required, EAS support[38], HR support was provided in terms of information and advice specific to the personal circumstances of the staff member, assistance with redeployment and redundancy options, Ms Dowell's "open door" approach to any staff member needing additional support or seeking further clarification and assistance, the culture of positive peer support encouraged by Ms Dowell and peer line managers, and consistent reminders from Ms Dowell about the importance and worthiness of the task at hand, communicated through weekly staff meetings to track progress with that work and check on individuals.

(g) At 3.3 of her supplementary statement, Ms Dowell states specifically:

> "… It is my opinion that support was adequate for a professional workforce".

At 5.5 of her supplementary statement, Ms Dowell further states:

> "I do not know how it could have been handled better. This question appears to suggest that the issue was handled poorly. I do not agree with that suggestion."

(h) At 15.1 of her supplementary statement, Ms Dowell opines:

> "In my view there was sufficient communication, support and assistance given to allied health staff in relation to the closure of the BAC. I am not aware of any additional communication, support and assistance options that could have been applied."

Statement of Michelle Giles[39]

101. Ms Giles' Affidavit bears relevantly on the issue of staff support. She deposes that:

(a) the dissemination of information and/or support for BAC staff in relation to closure was managed by Dr Geppert (as Director of Strategy) with input from the Workplace Relations and HR teams and the Operational Line Managers for staff including Ms Dowell (who reported to Giles) (paragraph 24);

(b) each of the clinical leads (Dr Stedman, Mr Brennan and Giles) reported on relevant staffing issues at the BAC update meetings and plans were formulated to resolve those issues, usually with input from Dr Geppert and the Workplace Relations/HR teams at West Moreton (paragraph 25);

38 EAS is a confidential process available to any staff member wishing to access it.
39 MGI.900.0001.0001.

(c) an organisation change meeting was convened on 28 November, 2013. Its purpose was to discuss, with HR, staff issues including voluntary redundancies, communicating with staff and communicating with Unions (paragraph 52);

(d) HR/staffing issues are identified as being raised and followed-up in Exhibit "D" to Ms Giles' Affidavit at pages 17, 19, 23, 29, 30, and 34.

Dr Stedman Testimony

102. In his statement, Dr Stedman expressed the opinion (page 9) that it was reasonable to expect that safe and effective transition of patients would be achieved from the closure announcement in August, 2013 to the anticipated flexible closure date of January, 2014. In testimony he said:

> "--- I think that there's a general view that for longer term, long-stay treatment plans that six months is a reasonable target for most people and most programs. So that's – that kind of time frame. So I just think if – if a program was working in a kind of contemporary way with a lot of attention to progressing things, I think five or six months should be reasonable." (at 19-42.25-30) (note that Professor McDermott gave similar evidence of a six months' time frame: see at 7-42).

103. At 19.43 and 44, Dr Stedman testified (regarding the transition period):

> "--- Well, as I said, I wasn't there for a lot of it but my sense of it from what I'm - what I've seen and what I saw when I came back was that there was no intention to reduce resources, that there – everybody was happy to provide whatever was needed to make the transition progress smoothly ... The intention was always to provide whatever was necessary to make it work properly." (19.43.40 to 19-44.1).

104. Dr Stedman further testified:

> "--- Again, as I said before, we'd been through many transition processes and this is very typical of what happens. So once a transition process starts, experienced staff start to look for long-term work. So that would have been factored – that would have been my expectation, that this process would be part of the process of transition." (19-59.1 to 5).

Testimony of Padraig McGrath

105. Mr McGrath testified:

(a) regarding the cessation of Redlands had an effect on staff available to allocate to BAC or the staffing mix:

> "Did that have an effect on staff who were available to allocate to the (BAC) or the staffing mix? --- No. ... The – the staffing mix in terms of the staffing profile didn't change. The staffing mix in the sense that some staff then started to seek other positions and leave Barrett then gradually over the months after August it started to change, yes ... Around about August 2013 or shortly thereafter." (19-4.30-45);

(b) "Does that accord with your recollection that even before the announcement there was, I suppose, tight margins or difficulty getting staff to the Barrett Adolescent Centre or some other problem? --- Not as I recall, no." (19-15.40 to 45);

(c) At 19.6 the witness was questioned about BPF which he identified as the Business Planning Framework, a component of enterprise bargaining for nursing staff brought in the QNU in consultation with the State. This outlines a formula for staff nursing units and looks at the staffing needs of a unit having regard to annual leave, training, and so on. At 19-6 (35 to 40), the witness said (regarding BPF):

> "It's considered in terms of funding and looking at your funding needs for the future year, and certainly it goes through the QNU who have a very strong oversight ensuring that their members' needs are looked after. Yes, so it has Union input ---

> ? --- Yes ... And it involves staff feedback and – you know, from the Grade 5, Grade 6s and the Nurse Unit Managers, yes ... The industrial bodies are very, very adamant about us staffing to out BPF." (See at 19-6 to 19-7.15);

(d) At 19-9.40 to 45, the witness stated:

> "The workforce team were – the workforce basically, was the HR department within West Moreton, and there was identified staff within the workforce team which were supporting staff in terms of looking at alternative employment, be that within or external to West Moreton. So they're available to provide assistance with (CVs), interviewing practice, that general kind of thing." (19-9.40 to .45).

(e) It is denied that staff who were speaking out were encouraged to take VERs: "What do you say about that? --- Not true." (19-17.10); and

(f) "Is it fair to say nurses are not known for being backward in terms of expressing views? --- I think it's safe to say – and I say this as one – mental health nurses are not known for being particularly reticent, no." (19-19.10).

11. TOR3(g). Any alternative for the replacement of BAC that was considered, the bases for the alternative not having been adopted, and any other alternatives that ought to have been considered

106. On the evidence, a number of alternatives were considered, although none of them figured as true "replacements" for BAC. The various alternatives were:

(a) "Bricks and Mortar";

(i) The Redlands Project – this project proceeded between 2008 and August, 2012, on which date it was ceased as a decision of Government. It was an initiative of the Mental Health Branch of Queensland Health whose responsibility it was to sign-off on the model of care for service delivery at the facility. On the evidence, the reasons for cessation were fiscal (including the state of the Queensland State budget and budgetary over-runs on the Project itself), planning, infrastructure and development delays in the Project itself, and the need to re-align the proposed model of care in conformity with a community-based model;

(ii) Reconstruction at The Park – this was investigated in the Site Option Report 2008 referenced in the closure submissions above and the investigation outcome is captured there. In summary, a new building at a different site on The Park campus was rejected as not feasible and a progressive rebuild at the present site at The Park was deemed to be inferior to the Redlands Project. For these reasons, the project did not progress;

(iii) Logan – this alternative was fleetingly investigated during August, 2013. The investigation appears to have been sponsored by the Mental Health Branch and/or CHHHS. Substantively, the investigation took the form of a site visit on 30 August, 2013 by Drs Stathis, Geppert, Sadler, in company with Kevin Rodgers. As documented in a contemporaneous email from Ingrid Adamson to Peter Steer and others of that same date.[40] As recorded, the outcome of the site visit disclosed that the Logan site would require consider refurbishment and had numerous unknowns including timing/cost/achievability. In consequence, this alternative did not progress;

(iv) Springfield Hospital - this alternative was addressed in evidence by Dr Kingswell[41]. The alternative appears to date from March, 2012, that is, prior to the decision to cease the Redlands Project. According to Dr Kingswell:

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40 Exhibit "D" to Ms Adamson's Affidavit affirmed 24 November, 2015.

41 13-20.35 to 13.21.10.

> "… We're talking about relocating a service to yet another site, starting the whole process of acquisition, design, approvals – I mean, I didn't rule it out. I sent it to Health Infrastructure Division. You can see that I wrote on it *Copies to --- Allan Meyer and Health Infrastructure Division*. I didn't rule it out, but I didn't think it was likely to be a viable option.
>
> Right. And you're, in essence, saying we've already spent a lot of money on Redlands and we'll lose some costs if we do something different now? --- And we'll delay. And we will delay."[42]

(b) Other alternatives:

(i) Queensland Health (Mental Health Division/CHHHS) new model of service and roll-out. Extensive treatment of this alternative is to be anticipated in the submissions of others, and will not be developed in written form in these submissions, at this time.

12. TOR3(h). The information, material, advice, processes, considerations and recommendations that related to, or informed the transition arrangements and other matters

107. This has been dealt with above.

13. TOR3(i). Whether any contraventions of the *Mental Health Act* 2000 or other Acts, Regulations or Directives have occurred with regard to patient safety and confidentiality

108. In Discussion Paper No. 4: Key Points,[43] the view of Counsel Assisting was this:

> "121. This TOR is extraordinarily wide. It could conceivably cover any breach by a patient of traffic regulations.
>
> 122. The Commission proposes to read the TOR as requiring an examination of any significant breaches.
>
> 123. Thus far the Commission has not identified any significant breaches".

109. Given that the treatment of this topic in Discussion Paper No. 4 has not been advanced in the submissions of Counsel Assisting it is assumed that no breaches have, in fact, been identified and, unless and until they emerge we make no submissions under this head.

Dated at Brisbane this 23rd day of March, 2016.

Kathryn McMillan QC

and Christopher Fitzpatrick

Counsel for WMHHS/B

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42 13-21.1-10.

43 Current as at 10 February, 2016.

APPENDIX A

THE STATUTORY FRAMEWORK

The position before 1 July 2012

1. Prior to 1 July 2012, the organisation, management and delivery of health services in Queensland was governed by the Health Services Act 1991 (**HSA**). Pursuant to that legislation:
    a. Health Service Districts were gazetted by the Governor in Council and comprised an area of the State, a public sector hospital or other public sector health service facility (s6). Health Services Districts did not have a legal existence separate to that of the State.
    b. The chief executive (the Director-General), subject to the Minister, had overall responsibility for the management, administration and delivery of public sector health services in the State. (s6B).
    c. he functions of the chief executive included, inter alia, ensuring the development of a State-wide health services plan s7(1)(b).
    d. A manager was appointed for each Health Service District (s22) whose functions included, inter alia, managing the delivery of public sector health services in the District in accordance with a health services agreement for the District (s23(a).
    e. In performing the functions, the manager was subject to the chief executive and the relevant general manager for the District.
2. Under that regime, the BAC was located within the West Moreton Health Service District, and prior to that, the West Moreton and Darling Downs Health Service District. It provided a State-wide service, being the single site adolescent mental health extended treatment and rehabilitation service for Queensland

The position following 1 July 2012

Upon the commencement of operation of the Hospital and Health Board Act 2011 (**HHB Act**) on 1 July 2012, the structure for the delivery of health services changed. The regime as from 1 July 2012 involved the following:

1. Overall management of the public sector health system is the responsibility of the Department of Health, through the chief executive (the Director General) (s8(2)). The Department is styled 'the system manager'.
2. In performing the system manager role, the chief executive is responsible for:
    a. Statewide planning;
    b. Managing Statewide industrial relations;
    c. Managing major capital works;
    d. Monitoring Service performance; and
    e. Issuing binding health service directives to Services (s8(3).

3. The functions of the chief executive include, inter alia:
    a. To develop State-wide health service plans and capital works plans.
    b. To manage major capital works for proposed public health sector facilities (s45).
4. The chief executive is subject to the direction of the Minister in managing the Department (s44F(1)).
5. Hospital and Health Services (HHSs) are statutory bodies corporate (s18(1)) and represent the State (s18(2)).
6. The functions of a HHS are set out in section 19 and include, inter alia:
    a. To enter into a service agreement with the chief executive (s19(2)(b); and
    b. To contribute to, and implement State-wide service plans that apply to the Service and undertake further service planning that aligns with the State-wide plans (s19(2)(d).
7. The way in which the chief executive's responsibilities are exercised establishes the relationship between the chief executive and the Services (s8(4)).
8. The relationship between the chief executive and the Services is also governed by the service agreement between the chief executive and each Service (s8(5)).
9. The chief executive and the Service must enter into a service agreement for the Service (s35(1) and the Chair of the HHB must sign the agreement on behalf of the Service (S35(2)).
10. The Service Agreement is binding on the chief executive and the Service (s35(3).
11. If the chief executive and the Service cannot agree on some or all of the terms of a Service Agreement within stated timeframes, they are to immediately advice the Minister and the Minister must decide the terms and advise the chief executive and the Service of the terms. The chief executive and the Service must include the terms decided by the Minister in the agreement (s38).
12. If the chief executive or the Service wants to amend the terms of a Service Agreement, and agreement cannot be reached, the party wanting the amendment must immediately advise the Minister and the Minister must decide the terms and advise the chief executive and the Service of the terms, and the Minister may decide that the amendment should not be made. The chief executive and the Service must include any terms decided by the Minister in the agreement (s39).
13. HHSs are individually accountable for their performance and are required to report on their performance to the chief executive (s9(1) and (2)).
14. Each HHS is 'independently and locally controlled by a Hospital and Health Board' (s7(2)) and each HHB appoints a health service chief executive (s7(3)).

15. Members of HHBs are appointed by the Governor in Council on the recommendation of the Minister for Health (s23(1) and, in the case of the positions of Chair and Deputy Chair, s25).
16. The HHB 'controls the Service for which it is established' (s22) and exercises 'significant responsibilities at a local level, including controlling:
    a. The financial management of the Service.
    b. The management of the Service's land and buildings.
    c. For a prescribed Service, the management of the Service's staff' (s7(4).
17. The Service Agreement between the chief executive and the Service states:
    a. The hospital services, other health services, teaching and research and other services to be provided by the Service; and
    b. The funding to be provided to the Service for the provision of services, including the way in which the funding is to be provided.
    c. The performance measures for the provision of services by the Service.
    d. The performance data and other data to be provided by the Service to the chief executive, including how, and how often, the data is to be provided.
    e. Any other matter the chief executive considers relevant to the provision of services by the Service.

Who had the authority to close BAC?

The statutory regime as summarised above makes it clear that:

1. The Department, through the chief executive is responsible for State-wide planning and for managing major capital works.
2. The relationship between the chief executive and the HHS is established and governed by:
    a. the way in which the chief executive's responsibilities are exercised; and
    b. the Service Agreement.
3. A HHS is required to enter into a Service Agreement with the chief executive.
4. Paragraph 133 of Counsel Assisting's submission posits that Service Agreements are entered into between the chief executive and the Chair of the Board. In fact, the Service Agreement is entered into between the chief executive and the HHS, with the Service Agreement being executed by the Chair of the Board on behalf of the HHS (s35).
5. Whilst the HHS is 'independently and locally controlled' by the HHB, the Service Agreement determines the services to be provided by the Services and is binding on the Service. It follows that:
    a. The HHS does not have the power to decide to cease a service which the Service Agreement states it is to provide.

b. The HHB may control the way in services are delivered by the HHS but cannot determined what services will or will not be provided.

c. In the event a HHS wishes to cease providing a service which the Service Agreement states the HHS must provide:

i. The agreement of the chief executive must be obtained.

ii. If such agreement is not forthcoming, the HHS is required to escalate the matter to the Minister, who has the final decision.

6. The first Service Agreement ('first Service Agreement') between WMHHS and the chief executive (WMS.1007.0484.00021) was entered into on 28 June 2012 and was for the period 1 July 2012 to 1 July 2013.

7. It stated in its terms that:

> *Based on the recent appointment of board chairs and members and the limited opportunity for the board to thoroughly understand the HHS it controls, the chief executive has decided the final terms of this first service agreement (in accordance with section 317 of the HHBA).*

8. Schedule 2 to the first Service Agreement provided:

> *The HHS has oversight responsibility for the following Statewide services provided by the Park:*
>
> *....*
>
> *Adolescent unit services.*

9. In paragraph 159 of their submission, Counsel Assisting discuss the phrase 'oversight role' and submit that it is difficult to regard the 'oversight role' as encompassing a right to close a facility'. The phrase 'oversight role' does not appear in this section of the Service Agreement.

10. The term used is 'oversight responsibility', which would reasonably be considered to include the exercise of governance over a service in including risk management and performance assessment and, if appropriate forming an opinion as to whether the service should continue to operate.

11. If such a view was formed, the HHB Act, the provisions of which relating to amendment of the Service Agreement are encapsulated in the terms of the Service Agreement itself, provide the mechanism for progressing to cessation of the service.

12. The table on page 7 of the Service Agreement reflects the amendment process in section 39 of the HHB Act, ie the terms of the Service Agreement, which are binding on the HHS align with the provisions of the legislation. Coupled with section 8(2) of the HHB Act which reserves to the Department the 'responsibility for the overall management of the public sector health system' including Statewide planning, it is clear that:

a. The system manager (ie the Department) had the authority to close BAC.

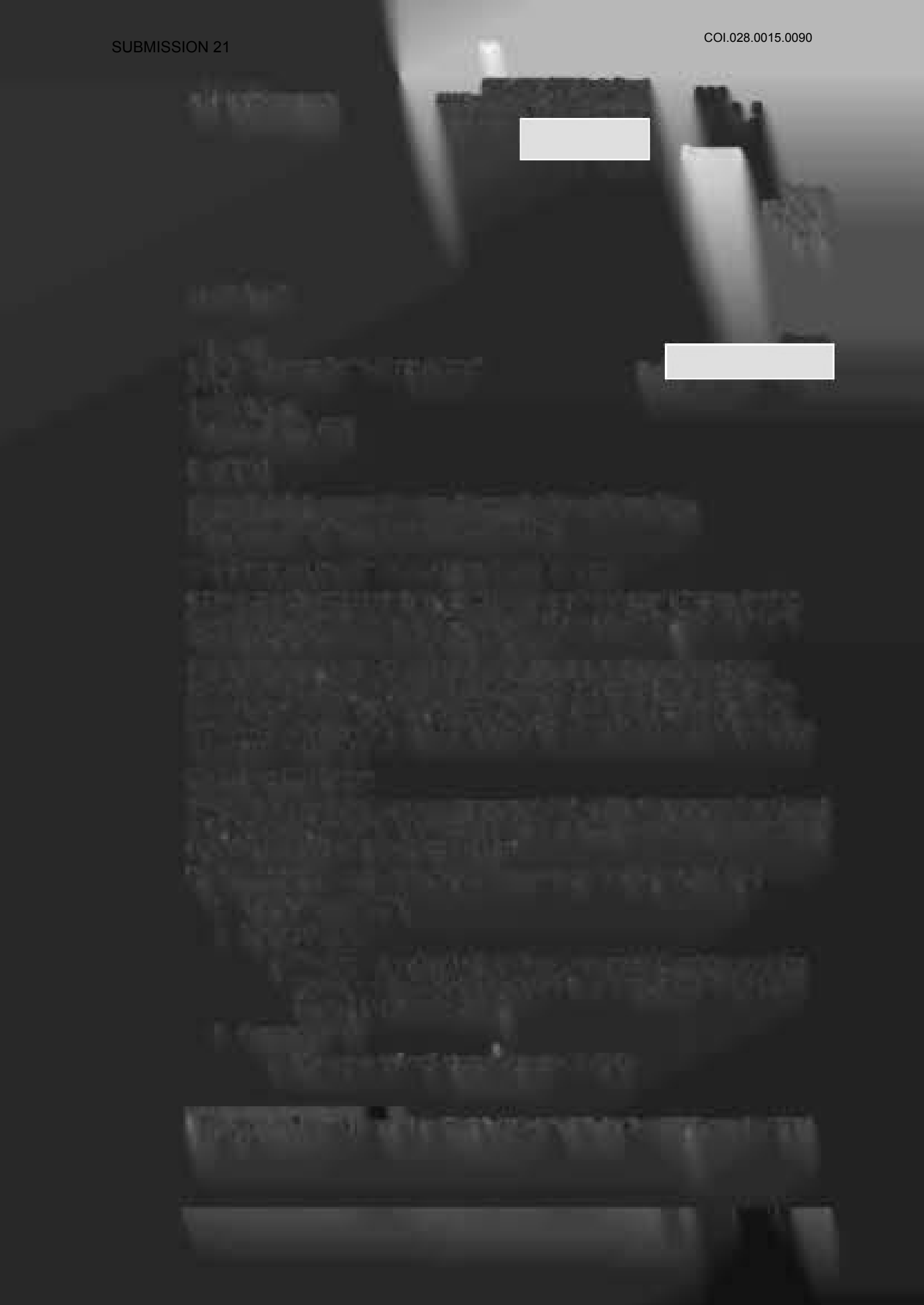
b. Neither WMHHS nor the WMHHB had the legal authority to close BAC without the approval of the Department as system manager.

c. Obtaining approval required engagement at the relevant officer level within the Department specified in the table on page 7 of the Service Agreement.

d. In the event that such approval was not forthcoming, the ultimate decision maker was the Minister for Health.

13. A Service Agreement in relevantly identical terms to the first Service Agreement was entered into for the period 1 July 2013 to 30 June 2016 (the second Service Agreement). By its terms and by reason of the framework outlined above, WMHHS continued to be required to provide the BAC service.

14. By amendment to the Service Agreement in the course of 2014, the obligation to provide the BAC service was removed from the Service Agreement. Counsel Assisting submit that 'peculiarly' no amendment was sought when other amendments were made to the Service Agreement in April 2014. Neither the Board Chair nor the health service chief executive was asked about this. It is uncontroversial that the Department and the Minister agreed to the closure of BAC in January 2014.



a. How Dr Corbett or the Board could have been reassured if they did not receive a written report or know what the services were or when they would become available.

12. Paragraph 227:

    a. It did not occur to Dr Corbett that Dr Brennan and the transition team were actually conducting the transitions on the basis of trying to adapt the BAC inpatients and waitlist patients to the existing services.

13. Paragraph 228 - The Consumer Feedback Summary Report was never put to Dr Corbett and no question was put to Dr Corbett regarding the seven complaints related to the closure of the BAC.

14. Paragraph 229:

    a. No question was put to Dr Corbett regarding the complaints related to the closure of BAC.

15. Paragraph 232:

    a. The 'plan for development of alternatives' lacked any real conviction.

    b. At the time the Board imposed the conditions (on closure), there is no evidence as to how the Board intended to satisfy themselves of this condition.

    c. Any such condition lacked any conviction or follow up.

    d. Dr Corbett was content with superficial updates at subsequent Board meetings and associated Agenda Papers.

Mr Eltham

The propositions in the paragraphs numbered 7 to 15 above were also not put to Mr Eltham, and in addition:

16. Paragraph 218:

    a. It is difficult to see what it was that satisfied him about that (that his concerns had been addressed).

The West Moreton Hospital and Health Board

Repeatedly throughout paragraphs 206 to 236, the submissions attribute states of knowledge, reasons for conduct etc to 'the Board', for example in paragraph 236 that 'the Board were not aware of what the services were'.

In circumstances where only two members of the then Board were called to give evidence, no information was sought or obtained regarding the state of knowledge of the remaining Board members and no propositions were put to any other Board members:

(a) Any propositions directed at 'the Board' beyond any matter stated in, and in the form stated in, the Minutes, is not properly submitted.

(b) The Board's decision cannot be attacked in the wholesale manner sought to be done in paragraph 216, 233 and 270.

Dr Geppert and others

Other matters never put include:

1. That there was a 'disconnect' between the recommendations of the ECRG and the Planning Group was never put to Dr Geppert or Ms Kelly.
2. Paragraph 215:
    a. What were the deliberations and what minutes existed in relation to the Planning Group was not put to Dr Geppert, Ms Kelly or other members of the Planning Group.
3. Paragraph 268:
    a. The assumption that a view was held that a Tier 3 facility ought not be considered was held.
    b. The assumption that such a view was held despite the express recommendations of the ECRG.

    In addition, it is unclear who is said to have had those views. Paragraph 268 does not state whether it is submitted that this 'view' was held by Mr Eltham (who is referred to in the preceding paragraph), the Board, or other unspecified person/s in the WMHHS.
4. Paragraph 233:
    a. There was no proper enquiry made about what services should be available to the BAC cohort and when.
5. Paragraph 270:
    a. No real or considered thought was given by the Board to alternative models of care at the time the decision was made to close BAC.

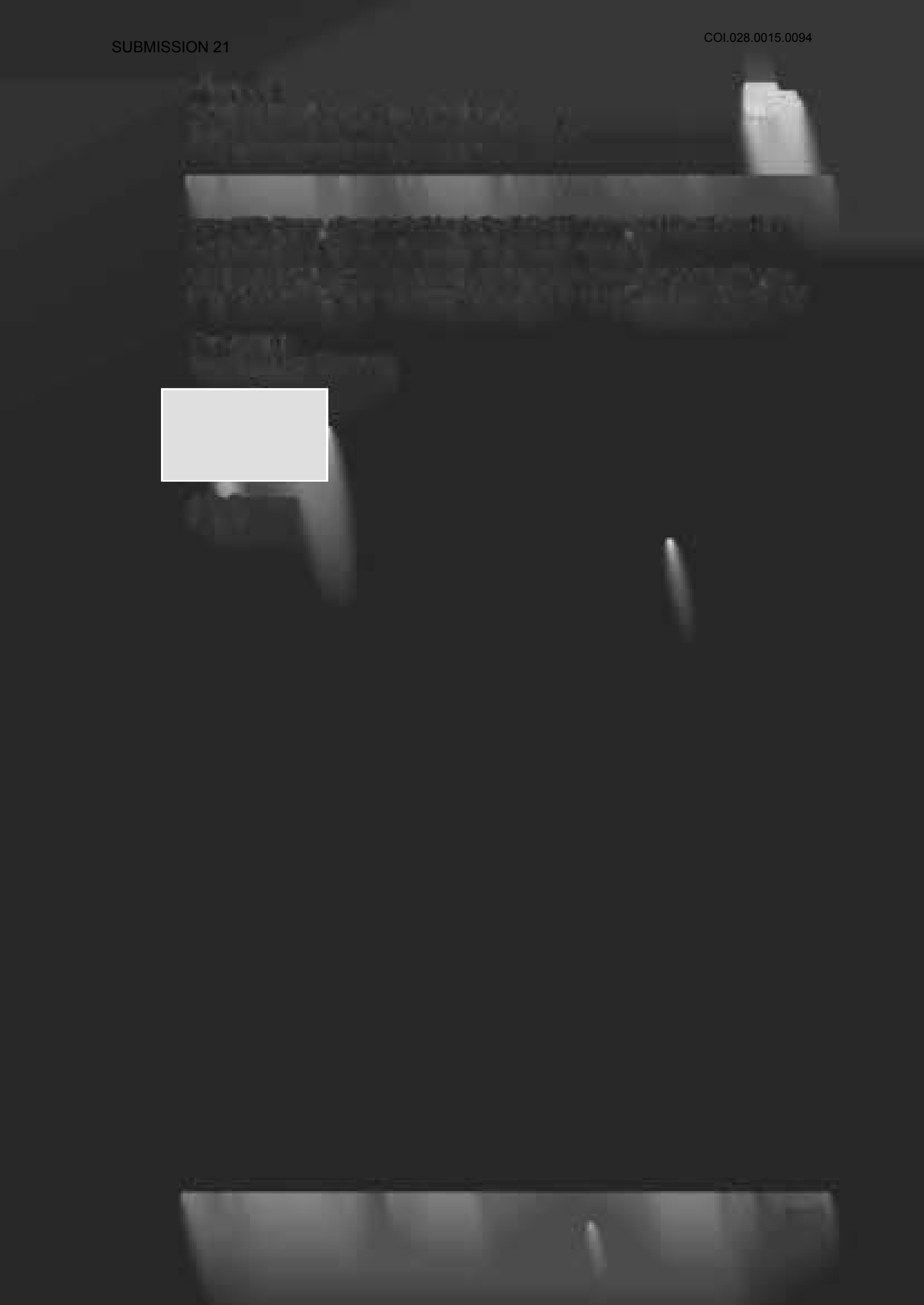
Dr Kotze

The only expert evidence called as to the transitions was from Dr Kotze, yet Counsel Assisting seek that her opinion be given little weight – see paragraphs 393 to 395 – without the matters suggested by Counsel Assisting for discounting her opinion being put squarely to her.

Other Examples

The submission relies on the statement of Mr Sault (paragraph 401). He was not called to give oral evidence and none of the matters in paragraph 401 were put to Mr Brennan or Mr McGrath.

In all of the circumstances, Counsel Assisting should either withdraw the abovementioned paragraphs or accept that evidence will need to be re-opened to allow the affected parties the opportunity to respond. Re-opening the evidence to address the above will necessitate at least the witnesses identified above being recalled. In the



situation where counsel assisting was to provide notice by way of closing submissions of the issues upon which potential adverse findings may be made. As you will be aware, this Commission is adopting a different practice. Possible adverse findings will be notified by the Commission subsequent to oral submissions and there will be an opportunity to respond in writing.

4. The Commission is concerned to ensure that parties are afforded a proper opportunity to respond to any possible adverse findings. That stage has not yet been reached. Indeed, counsel assisting's submissions were not intended to articulate the Commission's potential adverse findings, although they do raise some areas of concern raised by counsel assisting.

5. Second, you refer to *Duncan v ICAC* (& others) [2014] NSWSC 1018 (but do not identify the relevant paragraph relied on for the proposition). We have only briefly perused that decision and cannot identify the passage you are relying on for the proposition. It would assist if you could identify the paragraph which supports the proposition.

6. Importantly for present purposes, paragraph 36 of *Duncan* refers to the need to apply the requirements of natural justice flexibly in the circumstances of each individual inquiry.

7. Paragraphs 210 to 221 of *Duncan* also consider the issue of denial of natural justice – in the context of allegations of criminality. In paragraph 219 McDougall J said:

> "*It is correct to say that it was not put to any of the individual plaintiffs, in terms, that he had committed the offences that, in the Commission's view, could be made out. Nor was any of them cross-examined in detail on the elements of those offences. Nevertheless, each of them was cross-examined at length, in particular on all of the relevant facts that underlaid the Commission's findings. Each of them had the opportunity, both through his own counsel and in cross-examination, to deal with the facts.*"

8. At paragraph 220, His Honour concluded that, in the circumstances, it was not necessary to do more. His Honour concluded that:

> "*In particular, to require the preliminary formulation of views as to possible criminality to be put in detail, would seem to me to be inconsistent with the investigative nature of hearings in the Commission.*"

9. And so, we have some trouble identifying the foundation of your basic proposition. We would be grateful for your assistance.

10. It might also be of assistance if you expressly address the present circumstances where the Commission proposes to fairly inform the parties of any potential adverse findings. No potential adverse findings have not yet been formulated.

11. Further, as you will have noticed, limits were placed on all counsel so that the hearings could be completed on time. Dealing with the hearings in a proportionate way has been

necessary because of the exigencies. The Commission is nevertheless conscious that it is necessary to observe the rules of natural justice. That is all a necessary part of flexibility discussed by McDougall J in *Duncan v ICAC* at [36].

12. We now address some of your complaints about propositions not put. Because of the limited time available, this is not intended to be exhaustive.

Ms Kelly & Ms Dwyer

13. You complain about the summary in paragraph 231. That summary is based on the 6 propositions about the Agenda Paper at 207. Those 6 propositions are:

    a. The statement that the Planning Group accepted the ECRG's recommendations when the Planning Group appears to have not met in any formal way and they seemed unconvinced about the ECRG's central proposition that a tier was essential.

       Those aspects are clear from the documents themselves. See, for example, the preamble to the ECRG report. Some aspects were the subject of questioning: see the examination of Ms Kelly at T11-16; T11-22; T11-25 and the examination of Ms Dwyer at T12-99 (in fact Ms Dwyer positively disagreed with the ECRG).

    b. The ECRG's service model elements document allows for safe and timely closure.

       That aspect is a matter of looking at the ECRG report. Ms Kelly was asked about the Agenda Paper's advice that four-month time frame was appropriate (T11-17).

    c. The Agenda Paper's assertion that it was clinically adequate to provide a four month time frame was a matter expressly canvassed with Ms Kelly (the author of the Agenda Paper) – see T11-17 (Ms Kelly did not recall).

    d. Similarly, the Agenda Paper's assertion that the closure was not dependent upon service models was expressly canvassed with Ms Kelly (T11-17).

    e. Similarly with 'wraparound' – Ms Kelly (T11-18); see also Ms Dwyer (T12-99).

    f. The Agenda Paper's contention that closure could be commenced now was specifically addressed with Ms Kelly (T11-25) – which Ms Kelly agreed was an assertion by the Planning Group.

14. Of course, those are counsel assisting's submissions. Your client may well disagree. We invite you to make submissions explaining any factual contest. If there are further facts not in the existing witness statements, we invite you to explain them (see the discussion at the end of this letter).

15. Similarly with paragraph 261 (on page 72).

26. The contention that Dr Corbett and Mr Eltham appear not to have noticed any inconsistency [para 208] is a submission derived from their evidence on the issue. They seemed to, for example, accept that the ECRG said a tier 3 was essential, but nevertheless proceeded with the decision. Of course, if you client contends that is an error, by all means include that in your submissions.

27. Similarly with paragraph 209. The contention is that there is no evidence on a particular topic. If your client contends to the contrary, by all means include that in your submissions.

28. The position with paragraph 214 is similar.

29. It is true that, in paragraph 216, it is contended that the board's decision was inexplicable. That is a submission based on the evidence. Again, though, any contrary submissions ought to be made.

30. The same comments apply to paragraphs 227, 228, 229 and 232.

West Moreton Board

31. You are correct that only 2 members of the board were called (the chair and deputy chair). It is true also that it may be unlikely that findings can be made against the board or the members of the board other than the chair and deputy chair. Plainly, that will be borne in mind when it comes to drafting proposed adverse findings.

Dr Geppert and Others

32. You say that it was not put to Dr Geppert or Ms Kelly that there was a 'disconnect' between the recommendations of the ECRG and the Planning Group. We disagree. The ECRG's recommendations were put to Ms Kelly (T11-16). The Planning Group's recommendations (such as they are) were put to Ms Kelly (T11-12). Then, the difference in approach was put (T11-25). Dr Geppert was asked about the ECRG's recommendations (T10-18) and the Planning Group (T10-25).

33. It is true that no adverse finding has been articulated – the process has not got to that point yet.

34. Paragraph 268 (pages 74-75) lists some assumptions. It is not expressly stated but these are likely to be the views of Dr Corbett and Mr Eltham.

35. Paragraph 233 and 270 are negative propositions/submissions. They do not appear to be susceptible of a *Browne v Dunn* criticism (assuming the principle applies). Again, if the contrary is contended we are content to receive those submissions or evidence.

Dr Kotze

36. Questions of weight are a matter of submission and are not matters that need to be put to a witness. In any event, paragraph 394 is limited to an issue where Dr Kotze's own evidence was that she looked at 6 patients only.

Mr Sault

37. A number of witnesses, including Mr Sault, gave evidence that the nursing profile at BAC changed when it was decided to relocate BAC to Redlands, and when it was decided that the BAC would not relocate to Redlands, and when it was decided BAC would close. Not all of that evidence was consistent.

38. And not all of the evidence is as colourfully expressed. See the expression *"dumping ground"* in paragraph 9(c) of Mr Sault's initial statutory declaration which is the basis for the further answers referred to at [401] of counsel assisting's submissions.

39. Nevertheless, the changes in nursing profiles has been a live issue. A number of witnesses have commented on it.

40. Mr Sault's original statutory declaration, prepared by Ms Simpson (Roberts & Kane) was executed by Mr Sault on 15 December 2015. It was provided to all the parties on 17 December 2015. The supplementary statutory declaration was executed on 25 February 2016 and provided to the parties on 1 March 2016.

41. No party, including your client, advised that Mr Sault was required to be cross-examined. And a number of witnesses, including Ms Brennan and Mr McGrath gave evidence of the changes in nursing profile. No doubt that was done so that Mr Brennan and Mr McGrath's evidence on the issue could be properly put before the Commission.

42. In those circumstances, you might explain why there is unfairness. As you will know, it is often sufficient if the subject matter of a potential criticism has been flagged as an issue, in the presence of the affected person, during the course of the inquiry. See, in particular, Justice Hall's reference to the judgment of Wilcox J in *Bond v Australian Broadcasting Tribunal (No.2)* (1988) 84 ALR 646.

43. Of course, at present, there is no notice of any potential adverse finding. The change in nursing profile may or may not form part of such a notice. By all means explain any unfairness to your client. The Commission is prepared to assist where it can. However, at present, it seems to us that, even absent notices of potential adverse findings, the issue of nursing profile is an issue that has been raised and is one that your client has met with evidence.

Conclusions

44. Counsel assisting do not propose to withdraw any submissions. The point of the submissions, of course, is for there to be useful submissions from the parties addressing each issue. That will assist the Commissioner in making the relevant factual findings.

45. Counsel assisting have an open mind on whether further evidence should be permitted. In so far as you contend that further evidence ought to be tendered, please identify that evidence and provide a draft witness statement by 1 April 2016 so that the question of leave can be raised with the Commissioner.

Yours sincerely

APPENDIX C

RESPONSE TO COUNSEL ASSISTING'S CLOSING SUBMISSIONS

1. PART A: INTRODUCTION

Paragraphs 1 to 9

1.1. Counsel Assisting asserts that the first two fundamental issues are:

(a) Was there, and is there, a need for a facility like the BAC or its proposed replacement at Redlands?

(b) Can vulnerable young people with severe, persistent mental illness be accommodated in a facility such as the Lady Cilento Acute Adolescent Mental Health unit?

1.2. There is no Term of Reference requiring the Commission to inquire into whether there was a need for a facility like BAC or Redlands, much less any Term of Reference requiring the Commissioner to inquire into whether there is a need for such a facility.

1.3. There is no particular identification within the Terms of Reference requiring inquiry into the role of sub-acute beds. There is no Term of Reference relating to the adequacy of sub-acute beds in treating 'vulnerable young people with severe, persistent mental illness', a patient cohort considerably broader than the patient cohort at BAC.

1.4. Those issues are, at most, one factor of many relevant to Terms of Reference 3(b) and 3(c).

1.5. Elevating those questions to the status of 'fundamental issues', or indeed issues 'in their own right' at all, leads the reader inevitably into error .

1.6. Such conflation implies that the closure of the Barrett Centre is viewed in negative terms and that there necessarily ought to have been a replacement .

1.7. The need or otherwise for a particular type of facility (BAC, Redlands), and the suitability of one particular type of alternative unit (sub-acute units), are not and cannot be conclusive of, the actual questions posed by the Terms of the Reference:

(a) What were the bases for the closure decision?

(b) What information, material, advice, processes, considerations and recommendations related to or informed the decision and the decision making process?

Paragraph 11

1.8. The following proposition:

> *... There seemed to be little emphasis on ensuring that the decision is the correct decision or the best decision and is supported by proper and detailed analysis. The result is that the decisions made in this*

> *case appear to be based, not on any sound factual foundation, but rather in the unstable factual foundations of unattributed conversations and abbreviated or shorthand expression. The expression "contemporary models of care" is an example.'*

was not put to any witness, was not supported by the evidence (discussed in paragraphs 4.5 and following herof is in fact contrary to it and ought be rejected.

2. PART B: THE FIRST FUNDAMENTAL ISSUE – TIER 3

2.1. As noted in paragraph 5.3 of this submission, Counsel Assisting single out Dr Scott and Professor Hazell as having relevant expertise, purportedly on the basis (paragraph 15 of Counsel Assisting's submission) that they have 'direct clinical experience with adolescents aged between 13 and 17 years of age with severe, persistent mental illness'.

2.2. To the contrary:

(a) Professor McDermott has direct clinical experience with adolescents aged between 13 and 17 years of age with severe, persistent mental illness. [1], an example being his clinical stewardship of the Mater Child and Adolescent Mental Health Unit. Professor McDermott currently works as a private consultant child and adolescent psychiatrist. He additionally worked in 2015 as a locum Child and Adolescent Psychiatrist in the public health care system at Fraser Coast, Integrated Mental Health Service, Townsville Hospital and Health Service and West Moreton Hospital and Health Service[2].

(b) Dr Stathis has direct clinical experience with adolescents between 13 and 17 years of age with severe, persistent mental illness. Details are provided in his curriculum vitae[3].

(c) Dr Scott expressed limitations on his own experience, stating:

> *'I haven't worked within adolescent inpatient facilities as a director, as a consultant psychiatrist consistently since about 2010. I have done some periods of time working at it so – but – but I haven't had that consistent responsibility'[4]*

2.3. There is no basis for a submission that the evidence of Dr Scott or Professor Hazell ought be given more weight than that of the other experts whose relevant evidence is outlined in section 5 of this submission.

Paragraph 25

2.4. In the context of submission that Dr Scott supported a tier 3 option, the passage of Dr Scott's evidence quoted in paragraph 25 of Counsel Assisting's submission is selective and, when Dr Scott's answer to the question is read in

[1] Ex BMCM PBM .001.002.039
[2] PMB.001.002.001 @ 038
[3] DSS.001.001.001 @ 020
[4] T8-27

full, it is clear that Dr Scott does not support the submission made. Dr Scott stated:

> *In light of all of these things, is it your view that there is still value in the maintenance of a tier 3 facility going forward?*
>
> *I'm actually undecided upon that for a couple of reasons. I haven't worked within adolescent inpatient facilities as a director, as a consultant psychiatrist consistently since about 2010. I have done some periods of time working at it so – but – but I haven't had that consistent responsibility. I am aware that there's been some very interesting community based programs developed overseas and in other jurisdictions that I think are well worth a look at. I'm also aware when I went back to look through the evidence about extended hospitalisations and how effective are – are they, there's a real lack of evidence about whether or not they work. So I'm not strongly of a view that there should be or shouldn't be a tier 3 model in place. I think that people need to have a really good look at what the evidence is and what the other alternatives might be before investing such a large sum of money into a such a facility.*[5]

Paragraph 56

2.5. This statement is inadmissible. No evidence was given by Dr Breakey as to what was discussed or the basis for any conclusion that there was 'a consensus' for the BAC service continuing.

2.6. Nor is he even a member of the RANZCP.

Paragraph 57

2.7. Counsel Assisting detail, without comment or critique, the reasons for Dr Breakey's belief that closure of the BAC is flawed. In that regard:

(a) The proposition that 'there is no more contemporary model that is effective in treating this group of adolescents' is not supported by the evidence. The evidence is that there is no clear evidence base to support the effectiveness of the BAC model. In fact there is evidence to the contrary .[6]

(b) The proposition that 'the risk of harm from forensic patients is not a valid concern as Security Patients were sited at Wolston Park along with BAC since 1983 ...' fails to take into account that the EFTRU unit to be opened on The Park campus was a fundamentally different unit, with a different risk profile, to that of the patients sited at The Park up to that time. Dr Kingswell's evidence was that:

> *The EFTRU is a very different model of service. It's like a community care unit for mentally ill offenders. It's open. They can walk out. It has a gate.*[7]

[5] T8-27
[6] PBM2003 review para 101 PBM.001.002.018
[7]

Dr Kingswell had worked at Wolston Park since 1994. He described himself as having a 'fair visibility of BAC and other facilities on that site'. He was significantly better placed than Dr Breakey to understand the risk profile of EFTRU patients.

(c) Professor McDermott stated that he argued strongly against Wacol as the site for those reasons as follows:

> *'…I recall arguing strongly that the Wacol site was, in my opinion, not appropriate because it was on a large mental health campus, the site was increasingly a place of restricted care (for example, the building of the Medium Secure Forensic Mental Health Unit), and accommodation was to be provided for convicted sex offenders who had not been able to live in a community because of strong negative community advocacy following discovery of their identity and past history. I was of the opinion that one or more convicted sex offenders could in no sense be housed close to adolescents who were vulnerable because of mental illness and/or personal experience of abuse'*[8]

(d) The proposition that 'while the building has deteriorated, it could be refurbished cheaply' is simply not a matter on which Dr Breakey had any knowledge base, or at least not one that was evident from either his statement or his oral evidence.

Paragraphs 70 to 73

2.8. In these paragraphs, Counsel Assisting selectively quote those comments by Dr Sadler going to his belief as to the effectiveness of the BAC model. They do not address, for example:

(a) his contemporaneous email[9] in which he ponders whether *'from the high rate of subsequent suicide it could be argued that we are not very effective'*; or

(b) his explanation in oral evidence that:

> *'... that was a question that always went through my mind. You know, these young people are spending time in the unit. Are we helping them? Are we hindering them?'*[10]

(c) This anecdotal evidence is contextualised by Professor McDermott's evidence that his support for BAC, was posited on no reported suicides of patients and further that anecdotal evidence was not strong but on his assumption was relevant to the therapeutic benefit of BAC [11]

Paragraph 80

[8] para 53 PBM.001.002.010
[9] WMS.6006.0002.57727
[10] T23-77
[11] para 158 and 159 PBM.001.002.008

2.9. Counsel Assisting assert Ms Kelly was asked about the decision to relocate BAC to Redlands and she said "simply" that she imagined the QPMH was supported by expert advice. What is not reflected in paragraph 80 is that:

a) As is acknowledged elsewhere the Redlands project was not BAC.[12]

b) Dr Groves as the architect of the QPMH established expert groups for the purpose of developing the various components of the QMPH.

Paragraph 82

2.10. In this paragraph and elsewhere through their submission, Counsel Assisting refer to a tier 3 'facility'. The ECRG referred to a tier 3 service not a 'facility'. Dr Geppert amongst others made this very clear:

> *'a tier 3 service – which is not a building, per se, by the way, it's service options'.*[13]

Paragraph 85

2.11. Counsel Assisting submit that 'the ECRG was alert to the argument that the BAC cohort could be properly cared for by a combination of day program care, residential community based care and acute inpatient/hospital facilities. The ECRG rejected that argument'. That submission is incorrect and the extract from the ECRG quoted to support that submission does not do so.

2.12. The ECRG did not reject the argument. Rather, the ECRG noted that such an option carried risks. For the reasons outlined in paragraphs 7.19 to 7.27 of this submission, far from rejecting the argument, the ECRG recognised it was the most likely outcome, at least in the short term.

Paragraph 90

2.13. No evidence was led regarding the reasons for which the ordered be accommodated at BAC. The submission that this was 'no doubt because there were no other appropriate services' was not the subject the evidence, is unsubstantiated and speculative .

Paragraph 91

2.14. The proposition that 'did not fit into was not put to any relevant witness. The submission is not open on the evidence.

3. **PART C: THE SECOND ISSUE – SUB-ACUTE BEDS IN AN ACUTE UNIT**

Paragraph 93

3.1. The conclusion reached that a consensus of experts existed in relation to the necessity of a bed based medium term extended care and rehabilitation, appears to be based on paragraphs 14 – 88.

3.2. As is clear from the above submissions and the submissions of 23 March 2016, this is a selective representation of the evidence.

[12] para 179 Counsel Assisting's submissions

[13] T10-19:43-44

Paragraph 109

3.3. The proposition that Professor Kotze was the only expert who favoured beds on acute wards:

(a) is internally inconsistent with paragraph 112; and

(b) ignores the evidence of Professor McDermott and Dr Stathis as to the need for such beds.

4. PART D: THE LEGISLATIVE AND POLICY CONTEXT

Paragraph 120

4.1. The proposition that 'not surprisingly, the decision was made in a fragmented way, with no proper analysis, and for disparate reasons based on unsafe factual foundations' is not open on the evidence.

4.2. None of the following propositions were put to any relevant witness:

(a) That the decision was made in a fragmented way.

(b) That the decision was made with no proper analysis.

(c) That the decision was made for disparate reasons.

(d) That the decision was based on unsafe factual foundations.

4.3. The proposition that no person or entity took responsibility for the decision which led up to closure, is incorrect[14]

4.4. Broadly, no issue is taken with the outline of the framework and respective roles of the relevant entitles in the management of health services as set out in paragraphs 122 to 162 of Counsel Assisting's submissions, save that:

(a) Paragraph 133 states that Service Agreements are entered into between the chief executive of the Department and the Chair of the Board of the relevant HHS. In fact, Service Agreements are entered into between the chief executive of the Department and the HHS. Section 35 of the Hospital and Health Boards Act is in the following terms:

> ***Chief executive and Service must enter into service agreements***
>
> *(1) The chief executive and a Service must enter into a service agreement for the Service.*
>
> *(2) The chair of the Service's board must sign the agreement on behalf of the Service.*
>
> *(3) A service agreement is binding on the chief executive and the Service.*

(b) In respect of paragraph 159, refer to paragraph 10 under the heading 'Who had the authority to close BAC' in Appendix A to this submission. The term used in the Service Agreement is 'oversight responsibility' (not 'oversight role'), which would reasonably include the exercise of governance over a

[14] see evidence Dr Kingswell

service or unit such as the BAC, including risk management and performance assessment, and if appropriate, forming an opinion as to whether the service or unit should continue to operate. Oversight should be interpreted to include the right and responsibility to actively assess the costs, risks and benefits of operating particular units and, should a view be formed that a unit should be closed, to activate the appropriate legislative and contractual mechanisms to pursue closure. That is a different issue to a 'right to close' a unit and, as discussed below at paras xxx is what occurred in respect of the BAC.

(c) In respect of paragraphs 153 and 154, the Service Agreement[15] entered into on 28 June 2012 was for a one year period from 1 July 2012 to 30 June 2013 (not a three year period from 1 July 2013 to 30 June 2016).

(d) A second Service Agreement was entered into in respect of the three year period from 1 July 2013 to 30 June 2016.[16]

Paragraph 163(a)

4.5. The submission that the decision to close BAC was 'purportedly made by the WMHHB on 24 May 2013' ought be rejected. In that regard:

(a) The only decision of the WMHHB on 24 May 2013 in respect of BAC was that:

> *The Board approved the development of a communication plan and implementation plan, inclusive of finance strategy, to support the proposed closure of BAC.*

(b) The Minutes state as action items:

> *Minister to be updated regarding **proposed** closure* (emphasis added).
>
> *Minister's approval to be sought to not accept any further patients into BAC.*

(c) These action items are entirely inconsistent with a purported decision to close because:

(i) Had the WMHHB believed it was making a decision to close, the first action item would logically refer to updating the Minister regarding the 'decision to close'.

(ii) It is inconsistent with the WMHHB understanding that approval to cease accepting patients had to be obtained from the Minister. Any decision to close a facility would of necessity include not accepting further patients.

(d) Ms Corbett stated in her supplementary statement that:

[15] WMS.1007.0484.00021
[16] LJS.002.0001.0014

> *West Moreton Hospital and Health Board did not make any decision regarding the closure or the timing of closure at the meeting on 24 May 2013.*[17]

(e) Counsel Assisting took Ms Corbett to the Minutes of the meeting on 24 May 2013:

> *Now, Dr Corbett, I just want to get this clear. There is certainly no express decision by the Board that the BAC needs to be closed? – Correct.*
>
> *But would you agree with me that those minutes record that the Board is at least moving toward a closure of the BAC? – Yes.*
>
> *That's why the Minister is to be updated as to the proposed closure, etcetera? – And for his approval.*
>
> *Sorry? – And for his approval around the closure.*

(f) Counsel Assisting retreated from the proposition that a 'decision to close' was made by the WMHHB on 24 May 2013, putting to Dr Corbett that:

> *But if one reads these Board minutes, it looks – it looks, doesn't it, to any fair reader of it, that the Board is making a decision at least to move toward closure of the Barrett Adolescent Centre?*[18]

(g) Counsel Assisting asked Mr *Eltham 'am I right in thinking that this – these minutes don't – do not expressly record a decision by the Board to close the BAC, but it's implicit in it'*, Mr Eltham's evidence was:

> *Well, they don't record a decision by the Board to close the BAC because there was not a decision taken by the Board to close the BAC.*[19]

(h) No other Board members were called.

4.6. There was no evidence from any other Board member as to any decision of the WMHHB being made at the Board meeting on 24 May 2013 beyond that which is recorded in the Minutes.

4.7. In summary:

(a) The Minutes of that meeting do not record a decision to closure and are, in their terms, inconsistent with any such decision purportedly being made.

(b) The oral evidence of the Board Chair and Deputy Board Chair was unequivocal that no such decision was made at that meeting.

(c) No other Board member gave evidence of such a decision being made at that meeting (or at all) to close BAC.

(d) Correspondence from Counsel Assisting appears to acknowledge that such a finding against the entirety of the Board cannot be made.

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[17] Supplementary statement of Mary Corbett, para 1.2
[18] T9-44
[19] T9-3

(e) The subsequent actions of the WMHHS and WMHHB in seeking the approval of the Department and the Minister, in continuing to accept patients into BAC and in taking no steps to transition BAC patient until the approval of the Minister had been obtained, are inconsistent with the WMHHB having made or purported to have made a decision to close BAC.

Paragraph 164

4.8. This submission ought be rejected. For the reasons outlined in paragraphs 4.5 and 4.6 hereof, WMHHB did not make or purportedly make a decision to close BAC, and there is no evidence to substantiate the proposition that the WMHHB 'accepted itself as having the power to authorise the closure of the service'. The submissions in paragraphs 165 and 166 of Counsel Assisting's submissions correctly state the position.

Paragraphs 168 to 170

4.9. No witness was asked about the Deed of Amendment signed by the Department on 21 January 2014.

4.10. A footnote to paragraph 168 of Counsel Assisting's submissions notes that the only version available to it has not been signed on behalf of WMHHB.

4.11. Accordingly there is no evidence as to whether the Deed of Amendment was formally effected nor any evidence on which to make a finding that its contents are 'strange'.

4.12. In any event, the inclusion of a reference to the Statewide Adolescent Extended Treatment and Rehabilitation (AETR) Implementation Strategy in a Deed of Amendment dated 21 January 2014 to the WMHHS Service Agreement would not be 'strange', rather it most likely reflects that:

(a) As was the evidence of Dr Geppert and Ms Adamson, SWAERTI comprised three working groups, one of which related to the transition of BAC patients, a process which was not yet complete at the time the Deed of Amendment was executed.

(b) The process of addressing waitlist patients of BAC was still active at that time and although the governance of this had transferred to CHQHHS, staff of WMHHS including Dr Geppert, Dr Brennan, Kathy Stapley, Vanessa Clayworth and Laura Johnson continued to provide assistance to that process as at that date.

(c) Dr Geppert, an employee of WMHHS, was a member of the SWAERTI Committee.

(d) SWAERTI had reporting obligations to the Chief Executive and Director-General Oversight Committee which includes the Chief Executives of both CHQHHS and WMHHS.

Paragraph 171

4.13. The matters in paragraph 4.8(c) and 4.8(d) may also explain why no changes in respect of adolescent mental health services appeared in the further

Amendment Deed signed on 23 April 2014, but in any event no witness was asked about that Amendment Deed.

Paragraphs 173 to 176

4.14. No witness was asked about the timing of the Amendment Deed removing WMHHS's obligation to operate BAC.

4.15. The evidence is that:

(a) It was the system manager who had the authority to close BAC (acknowledged in paragraph 162 of Counsel Assisting's submissions).

(b) The system manager's agreement to the closure of BAC was given (acknowledged in paragraph 163(c) of Counsel Assisting's submissions).

(c) Such agreement preceded, or was made unnecessary by the agreement of the Minister, which is acknowledged in paragraph 163(b) of Counsel Assisting's submissions to have been given on or between 15 July 2013 and 31 July 2013.

(d) BAC continued to provide care to patients until the end of January 2014 and actions to address the waitlist for BAC continued until around March 2014.

4.16. There was no basis to record removal of BAC from the operational responsibility of WMHHS until the last of those steps was taken.

4.17. Amendment Deeds are entered into quarterly, and accordingly the 2014 mid year Deed of Amendment was the appropriate instrument for recording that cessation of responsibility.

4.18. It in no way reflects a 'lack of clarity about the legal responsibility for the decision' nor does it reflect a 'lack of any rational process in the decision making'. The submission in paragraph 176 was not put to any witness and is not open on the evidence.

Paragraphs 184 , 186 , 188, 192(c) , 194 ,195 , 196 and 204

4.19. The following propositions in these paragraphs were not put to any relevant witnesses and are not open on the evidence.

184	The briefing note is remarkable not for its content but for the lack of supporting reports or information…And yet the decision to cancel that decision is said to have been made with no support from experts and no identifiable 'sector consultation'.
185	That Dr Kingswell, Dr Geppert and Dr Young were confident enough to put such a proposition to Dr O'Connell in the absence of supporting information and expertise is surprising
188	That original expert advice was ineffect disregarded ...Each of those 3 reasons is unsupported in the sense that no direct information was obtained from Professor Crompton and his team.

192(c)	The theory is raised as a slogan without any specific detail (what aspect of the model is not contemporary and why?)
194	… On that basis, it is odd to use that draft as evidence that a particular service is no longer contemporary and to do so without seeking the advice of a child and adolescent psychiatrist.
195	… Nevertheless, it may have been an influence.
196	The result is a decision that seems some distance from both a factual foundation and proper expert advice.
203	But, the problems with the decision are these: (a) there were no documents or reports or advice which recorded the advice to the Minister that the Redlands project was "not the appropriate model of care and the project should be ceased"; (b) there were no documents or reports which addressed the consequences of the decision to cancel 3 projects and defer a 4th project; (c) that must have made it difficult to perform a balancing exercise which assessed the competing demands for the $41 million in taxpayers money;
204	On the evidence the likelihood is that this was a political decision, made by the Minister without any analysis or balancing of competing demands. Further, the likelihood is that the Minister made the decision without any advice from Queensland Health and without consideration of the consequences of the 4 cancelled or deferred projects.
205	... But it is more than a little surprising that the decision is not supported by any reports, or analysis, or detailed consultation and that there is not a hint of advice or caution from the department, let alone from Dr Kingswell or Dr Young.

Paragraph 206

4.20. For the reasons outlined in paragraphs 4.4 and 4.5 hereof, the submission that on 24 May 2013 the WMHHB 'decided (albeit in opaque terms) to close BAC' is incorrect. The WMHHB neither made nor purported to made a decision to close BAC.

Paragraph 207

4.21. Counsel Assisting's submission as to the matters said to have been put by Ms Kelly to the Board in the Agenda Paper for the Board meeting of 24 May 2013 is a gross distortion.

Paragraph 207(a)

4.22. It was never put to Ms Kelly that the Planning Group did not formally meet to consider the ECRG report. To the contrary, Counsel Assisting took Ms Kelly to a note and stated *'so far as I can tell, this is the only note we have of that meeting of the planning Group after the ECRG was received'.*[20] It was implicit from Ms Kelly's evidence in relation to the note that her evidence was that such a meeting did take place.

4.23. Dr Geppert's evidence was that there was such a meeting[21]. It was never put to her that there was not.

4.24. It appears to be inferred on the basis that 'there are no minutes of any Planning Group meeting after the receipt of the ECRG report'. In that regard:

(a) The footnote transcript reference to this in Counsel Assisting's submission is a reference to the oral evidence of Dr Corbett who was not a member of the Planning Group and whose evidence at the transcript reference does not relate to this topic.

(b) Dr Geppert gave evidence that the Planning Group met six to seven times over the period of its operation and that formal minutes were not kept of any of those meetings[22]. Accordingly, no inference can be drawn from the absence of formal minutes.

(c) Dr Geppert gave evidence that rather than formal minutes, the record of the meetings took the form of action sheets[23].

(d) The action sheet for the meeting of the Planning Group following receipt of the ECRG report was tendered by Counsel Assisting[24].

4.25. The submission that the Planning Group did not formally meet to consider the ECRG report is not open on the evidence.

4.26. Dr Stathis, Dr Sadler, Dr Kingswell and Michelle Bond provided feedback.[25]. Dr Geppert confirmed she was present at the meeting[26]. Ms Kelly chaired the meeting. No evidence was sought from Ms Thorburn, Dr Hartman or Ms Ford, but in any event:

(a) The attending members of the Planning Group plainly constituted a quorum.

(b) Ms Kelly did not agree with the proposition put to her by Counsel Assisting that the absence of notes of input from those members meant they were not present but indicated only that the notes of input from four members meant only that those four people had particular commentary to make[27].

[20] T11-20
[21] T10-24
[22] T10-24
[23] T10-24
[24] Exh 00222
[25] Exh 00222
[26] T10-25
[27] T11-20

4.27. The Board Paper does not refer to any unanimity within the Planning Group nor is there any evidence that a unanimous position was expected or required of the Planning Group.

4.28. To brand the statement that 'the Planning Group accepted all recommendations of the ECRG with some caveats' as 'something of an exaggeration' is an unsubstantiated slur on Ms Kelly. In that regard:

(a) That statement is not 'something of an exaggeration'. It is a correct statement of the position.

(b) The acceptance by the Planning Group of the ECRG recommendations and the caveats placed on those by the Planning Group were explicitly stated in the Planning Group Recommendations. It is not the case that the Planning Group's caveats were unclear.

(c) If there is any room for differing interpretations of the statement made in the Board Paper (and it is submitted that there is not), the statement, in any event, had no capacity to mislead the WMHHB because the Planning Group Recommendations document was attached in full to the Board Paper for the Board members' review.

4.29. The proposition that 'in fact the Planning Group were unconvinced about the ECRG's central proposition that a tier 3 facility was essential' is not substantiated. In that regard:

(a) This submission is another example of Counsel Assisting conflating tier 3 with a 'facility'. The ECRG report refers to a 'tier 3 service' and nowhere refers to a 'tier 3 facility'.

(b) The submission elevates Recommendation 2 of the ECRG report to a 'central proposition'. The ECRG report makes seven recommendations and does not identify any one or more of them as 'central'.

(c) The Planning Group Recommendations do not state, nor do they reflect, that the Planning Group was 'unconvinced' about Recommendation 2. They explicitly state the Planning Group's qualified acceptance of the recommendation and the specific reasons for qualified acceptance, ie the stated caveats.

Paragraph 207(b)

4.30. The ECRG report specifically contemplates the scenario of BAC closing in circumstances where no tier 3 service has yet been established. The report identifies a way forward, ie interim service provision for current and waitlist consumers of BAC prioritising the needs of these individuals and their families[28].

4.31. This is entirely consistent with the proposition that 'the ECRG's service model elements document and associated recommendations for an alternative model of service allowed for safe and timely closure'.

[28] Recommendation 3(b)

4.32. Further and in any event, the Board Paper had no capacity to mislead the WMHHB because the ECRG Report was attached in full to the Board Paper for the Board members' review.

Paragraph 207(c)

4.33. Ms Kelly's evidence was that she could not recall who decided that it was clinically adequate to provide a four month timeframe.[29]

4.34. She not asked whether she sought advice or from whom. It was not put to her that there was no such advice.

4.35. The proposition that there was no such advice was not put to any other relevant witness and is not open on the evidence.

Paragraph 207(d)

4.36. The proposition that 'closure of the BAC was not dependent on a new statewide service model' is not inconsistent with the ECRG warning of risks if the BAC closed without the availability of a new tier 3. In that regard:

(a) Whilst identifying risks, the ECRG report also identifies a way forward to manage that risk, as outlined in paragraph 4.31 hereof.

(b) As Ms Kelly explained in her evidence:

> *... [closure] was not reliant on there being service models available?---it was not reliant on a final, state-wide service model, that is correct.*
>
> *Instead it was dependent upon wraparound services being available?---It was dependent on making sure that every adolescent that we had in our care at that particular point in time was provided with appropriate services going forward.*
>
> *What were those wraparound services? Was there a model of service for them? --- It's – it's an individualised service plan, so, from my perspective, that meant that each of those individual adolescents or young adults would have been identified as to their needs and an appropriate package of care or wrap-around service was developed individually.*[30]

Paragraph 207(e)

4.37. Again, the statement in the Board Paper that 'the closure process is relevant to the needs of the current and wait list consumer group of BAC, and the capacity for 'wrap-around' care' is not inconsistent with the ECRG warning of risks if the BAC closed without the availability of a new tier 3. To the contrary, it is entirely consistent with the ECRG report, which recognised there were risks but also identifies a way forward to manage that risk, that way forward being precisely the process identified in this statement in the Board Paper.

Paragraph 207(f)

[29] T11-17
[30] T11-18

4.38. Ms Kelly identified that Dr Kingswell was *'the key accountable officer for mental health and strategic planning and services across the State*'[31]. As such he was the member of the Planning Group with the most intimate knowledge of what would be possible in relation to alternative services development. It was reasonable and appropriate for Ms Kelly, and the Planning Group, to accept his advice on that matter.

Paragraph 208

4.39. For the reasons outlined in paragraphs 4.31 to 4.38 hereof, the proposals in the Agenda Paper were not contrary to the ECRG's recommendations. The submission that they are, ignores that:

(a) The ECRG explicitly recognised the scenario of BAC closing in circumstances where no tier 3 service was yet operating.

(b) The ECRG did not make any recommendation to the effect that 'this ought not occur' or that it 'could not be safely managed'. To the contrary, the ECRG identified the risks involved in that, and made recommendations as to the appropriate steps to be taken to manage those risks.

(c) Those appropriate steps did not include ensuring BAC remained open for any specified period of time, or at all. Nor did they include deferring any decision regarding the future of BAC for any period of time or until other options had been considered.

4.40. Ms Kelly's reasons for her view that closure was independent of any service model were well explained by her in her oral evidence and were not seriously challenged.

4.41. Counsel Assisting's submissions do not identify any flaw in those reasons, other than simply clinging to one part of the ECRG report whilst ignoring the ECRG's own qualifications to that part of their report. The report must be read as a whole, and the failure to do so results in a significant distortion of the ECRG's position.

4.42. There are a number of objections to Counsel Assisting in cross-examination asking selective passages from documents or documents of which the witness was not an author and hence any assertions made need to carefully examine what the evidence actually is. [32]

4.43. Neither Dr Corbett nor Mr Eltham were asked about any 'inconsistency' between the ECRG's views and the proposal in the Board Paper.

Paragraph 209

4.44. Neither Dr Corbett nor Mr Eltham were squarely asked what debate or considerations the WMHHB had of the content of the Agenda Paper.

4.45. It was not put to either of them there was no, or no sufficient, debate or consideration by the WMHHB of the content of the Agenda Paper.

[31] T11-70
[32] 11-20, 11-22,11-28 ,11-10

4.46. Neither Dr Corbett nor Mr Eltham were asked about their knowledge that the capital project for a replacement BAC had ceased due to unresolvable building an environmental barriers.

4.47. Neither Dr Corbett nor Mr Eltham were asked whether any Board members asked what the barriers were and why they could not be resolved.

4.48. No other member of the WMHHB was called to give evidence or requested to provide evidence in a statement.

4.49. In any event, the Board had been aware since at least 9 November 2012 that the Redlands project had been ceased[33].

4.50. There is no evidence on which to draw any adverse inference regarding the nature or extent of the WMHHB's debate or consideration of the content of the Agenda Paper.

Paragraphs 210 to 212

4.51. The proposition in these paragraphs is that there was no foundation for Ms Kelly to put forward propositions that:

(a) The stated basis for cessation of the Redlands project (unresolvable building and environmental barriers); and

(b) Closure of BAC aligned with the strategic direction of the HHS and the QMPH;

And accordingly she had no proper basis for stating either of those propositions.

4.52. The submission in paragraph 210 regarding cessation of the Redlands project is not open on the evidence. There was a wealth of evidence, including that of Dr Kingswell[34], Dr O'Connor[35] and Dr Sadler[36] that the Redlands project had insurmountable building and environmental problems.

4.53. The relevance of this to the considerations of the WMHHB is, in any event, unclear. In that regard:

(a) Neither WMHHS (or its predecessor) or WMHHB had any control in the development of the Redlands project.

(b) WMHHB had been informed six months earlier that the Redlands project had been ceased.

(c) WMHHB was not consulted in that decision, had no decision making role in it and no ability to effect a reversal of the decision.

4.54. It cannot seriously be suggested that there was any utility in the WMHHB 'second guessing' the reasons for the Department making a decision to cease the Redlands project.

[33] Exh 50 - Statement of Timothy Eltham and annexure TCE-07 to that statement
[34] T13-9
[35] Exh 94 – Statement of Dr Tony O'Connell
[36] QHD.004.014.7257.

4.55. The submission in paragraph 211 is not open on the evidence. Ms Kelly gave evidence in response to a question from counsel for Mr Springborg that the basis of her understanding that closure of BAC aligned with the QPMH was the information provided to her in the meeting she attended with Dr Kingswell, Dr Geppert and Dr Gilhotra on 25 October 2012[37]. This was consistent with the information provided in her written statement[38].

4.56. Ms Kelly identified in her evidence that Dr Kingswell was 'the key accountable officer for mental health and strategic planning and services across the State'[39]. There can be no suggestion that she ought not to have relied on his advice on a matter of alignment with State mental health policy.

4.57. The propositions in paragraphs 210 and 211 of Counsel Assisting's submissions having no evidentiary basis, the submission in paragraph 212 is not open.

Paragraph 213

4.58. The action items are not 'obtuse'. They logically and correctly reflect that the decision made by the WMHHB on 24 May 2013 was not a 'decision to close' BAC but a decision to support closure. They both reflect and recognise that any such process required the agreement of the Department and/or the Minister and that the appropriate next steps were to progress requests for same.

4.59. It is correct that no actual decision to close BAC is specifically recorded. That is because no such decision was made, as outlined in paragraphs 4.5 to 4.7 hereof.

4.60. The proposition that 'the combination of the various items in the minutes makes it clear that a decision was taken at this meeting to close the BAC' is contrary to the evidence, as outlined in paragraph 4.5 to 4.7 hereof.

4.61. The phrase 'or at least, a decision to move towards closure' was used by Counsel Assisting in questioning of witnesses but does not appear anywhere in the Board minutes for the mee3ting of 24 May 2013. Its meaning is unclear. Certainly, it means something different to a decision to close.

4.62. The Board action item that the Minister was to be updated regarding proposed closure does not 'assume a decision to close'. To the contrary, it expressly reflects that a decision to close has not been made, closure is merely 'proposed'.

4.63. The submission that the minutes note 'steps were to be taken to cease further admissions' is not an accurate reflection of the minutes. The minutes record that the Minister's approval is to be sought to not accept further admissions. Implicit in this is a recognition by WMHHB that it did not have the authority to make such a decision, and it is inconsistent with any belief that it could or did make a decision on that date to close BAC.

[37] T11-69
[38] Statement of Ms Kelly and annexure SK-9 to that statement
[39] T11-70.

Paragraph 214

4.64. It was not put to either Dr Corbett or Mr Eltham that they did not properly read or note the views of the ECRG.

4.65. In any event, their oral evidence was contrary to such a proposition. Both gave intelligent, informed explanations of their understanding of the ECRG report and its role and significance in the process.

4.66. None of the matters to which Dr Corbett and/or Mr Eltham were taken (referred to in paragraph 214 of Counsel Assisting's submissions) support the proposition that 'the decision that was taken was contrary to the recommendations of the ECRG'. Once again, the submission reflects a singular focus on Recommendation 2 of the ECRG whilst ignoring the ECRG's further statements in Recommendation 3. The ECRG report must be read as a whole, and the failure to do so results in a significant distortion of the ECRG's position. The decision of the WMHHB was not contrary to the recommendations of the ECRG when the ECRG recommendations are read in full.

Paragraph 215

4.67. This submission is not open on the evidence.

4.68. Further, it is incorrect that 'the Planning Group made comments in the right hand column of the ECRG Report'. The Planning Group Recommendations form a separate document to the ECRG report. They are attachments 2 and 3 respectively to the Board Paper, as is clear on the face of the material as presented to the WMHHB.

Paragraph 216

4.69. This proposition was not put to any relevant witness and for the reasons outlined in paragraphs xxx hereof, is not open on the evidence.

4.70. Further, the proposition reflects an absence of understanding as to the role and structure of Board minutes. Board minutes record decisions made by a Board. They do not record, and are not intended or expected to record, the deliberations by the Board which occurred in the making of those decisions. T

Paragraph 217

4.71. Mr Eltham's email has been taken out of context. As he explained in paragraph 11.13 of his statement[40], Mr Eltham's email was referring to the absence of funding for a capital project (his email having been prompted by being informed that the Redlands project had been cancelled). It was not connected to the question of concerns about alternative services for current BAC patients.

Paragraph 218

4.72. The proposition that 'it is difficult to see what it was that satisfied him about that' is not open on the evidence. In that regard:

[40] Exh 50 - Statement of Timothy Eltham, para 11.13

(a) Neither Mr Eltham nor the other members of the WMHHB were mental health clinicians[41]. They were not in a position to, nor is the role of a Board member, to engage in assessing specific clinical details of individual patients' care.

(b) Mr Eltham's evidence in his statement[42] and in his oral evidence[43] was that the WMHHB received updates from the WMHHS executive at each monthly meeting until January 2014 as to the status of BAC patients and transition arrangements (in a governance and operational sense, not on a patient-specific basis).

(c) The Board Papers for each of those meetings reflect that an update was provided at each meeting.

Paragraph 220

4.73. The proposition that 'it is difficult to see how they [Dr Corbett and Mr Eltham] or the Board could have been sufficiently satisfied. In that regard:

(a) The proposition is vague.

(b) There was ample evidence from Dr Corbett and Mr Eltham, in the statements and oral evidence of both, that monthly updates were provided to the WMHHB.

(c) Dr Corbett's evidence also was that:

> *We were also assured by the fact that our executive were in very close contact with the department, with the Mental Health Alcohol and Other Drugs unit as well. So the decision was not being made by a single individual[44].*

(d) The Board Papers for each meeting reflect this.

(e) To suggest that Board members should delve into the specific clinical circumstances of particular patients (as seems to be inferred) reflects a absence of understanding as to the role of a Board. As Dr Corbett stated:

> *The Board governs the whole of the Hospital and Health Service. That includes hospitals. Barrett is one unit of it. If I can try and draw a parallel, I think what you're suggesting is that we should be sure that if a clinician in any of our services discharged a patient – so maybe an emergency department physician discharged them – that we had a responsibility to ensure that that was correct. That's not a role for the Board. That is an operational matter and it is certainly a role for the clinicians[45].*

4.74. It is unreasonable to expect a Board Chair to remember, more than two years after the event, the specific date for when the mobile outreach service become

[41] T9-14
[42] Exh 50 – Statement of Timothy Eltham, para 26.16 and 26.17
[43] T9-16, T9-22
[44] T9-57
[45] T9-57

available nor the day program, both because of the time which has elapsed in the interim and because it is a misconception of the role of a Board to expect a Board Chair to retain such detailed knowledge of clinical services outside the HHS for which her Board is responsible.

Paragraph 223

4.75. Each of the witnesses were able to give evidence as to the type of services available. They in turn relied on information from the executive, as they were entitled to do.

4.76. Furthermore, Mr Eltham had been involved in "Project 300" and was aware of issues relating to such a process.

4.77. This paragraph ignores the evidence that the Board did receive updates as to patient discharges in the Board Papers from August 2013 to January 2013.

Paragraph 224

4.78. Dr Brennan and Dr Hoehn were involved in the transition of individual BAC patients. The inference that the Board ought to have been involved in or to have sought details of such matters, or that it should be criticised for failing to do so, should be rejected. In that regard:

(a) The evidence of Dr Corbett[46] and Dr Eltham that it was not the role of the WMHHB to involve itself in individual clinical cases.

(b) The evidence of Dr Corbett[47] and Mr Eltham[48] was that they were aware that Dr Brennan was reporting to the executives of the WMHHS Mental Health team.

(c) Difficulties encountered by Dr Brennan and Dr Hoehn can only have concerned individual patient clinical matters, which was not a matter for the WMHHB.

(d) There is, in any event, no evidence that involvement by the WMHHB may have resulted in different or better outcomes in the resolution of any such difficulties, nor was any such proposition put to any witness.

Paragraph 225

4.79. It was not put to Dr Corbett or Eltham that the Board ought to have considered, or decided to 'stop; the closure at any point.

4.80. The submission misrepresents the position or Dr Corbett and Mr Eltham, which was that the primary concern of the WMHHB was the welfare of the particular patients then in BAC. The WMHHB had no governance responsibility in relation to the broader cohort of 'adolescents with persistent or severe mental health conditions'. There is no evidence that any BAC patient could not be safely and appropriately cared for in the alternative arrangements available to or structured for, that individual at the time of their transition from BAC. There

[46] T9-55, T9-57
[47] T9-55
[48] T9-17

was, therefore, no basis on which the WMHHB ought to have suggested the closure be 'stopped'.

4.81. The submission also ignores the evidence of Dr Stedman and others that once closure has been announced and the process of closure commences, it is contrary to patients' best clinical interests to delay transition.

Paragraph 227

4.82. It was not put to Dr Corbett that 'Dr Brennan and her team were actually conducting the transitions on the basis of trying to adapt the BAC inpatients and waitlist patients to the existing services'.

4.83. Further, that proposition is incorrect on two levels:

(a) Dr Brennan's evidence was that the majority of BAC were able to be transferred to existing services without difficulty[49].

(b) For the remaining patients, the process was one of tailoring services to patient needs, which is the process of 'wrap-around services' referred to in the ECRG[50]. It was not a process of adapting patients to services, and Dr Brennan did not describe it as such.

4.84. The uncontroverted evidence of Dr Brennan, Ms Clayworth and Professor Kotze speaks to the adequacy of the discharges and transitions.

4.85. The inference, if such is sought to be raised, that it was not appropriate for Dr Corbett to rely on the fact that a transition had occurred as inferring that appropriate services were available to the young person, requires that Dr Corbett have some suspicion that WMHHS clinicians, and in particular Dr Brennan, would facilitate or allow a transition of a patient in circumstances where they held the view that the transition was not clinically safe and appropriate. There is no such evidence, and this is not a position that Dr Corbett ought to have assumed.

Paragraphs 228 and 229

4.86. The documents referred to were not put to any relevant witness.

4.87. There is nothing on the face of the documents to indicate that they relate to individual patients.

4.88. It was put to Dr Corbett that there were complaints that BAC was closing or that it was closing too quickly. Her evidence was that it was *'more of the fact it was closing'*[51].

Paragraph 230

4.89. It is a misconception that Mr Eltham 'conceded' that there was no precise delineation of 'wrap around' services. They are, by definition a bespoke plan

[49] T20-36 @ 43 – T20-37 @ 7
[50] T20-67 @ 45
[51] T9-52

prepared for an individual, not a defined 'package of care' or similar which is capable of precise delineation.

4.90. In any event, as previously noted, this proposition does not sit with the uncontroverted evidence of Dr Brennan, Ms Clayworth and Professor Kotze as to the adequacy of the discharges and transitions.

Paragraph 231

4.91. For the reasons outlined:

(a) The Board did not arrive at a decision to close the BAC.

(b) The Agenda Paper did not lack factual foundations.

(c) The ECRG excerpt repeatedly referred to in Counsel Assisting's submissions and which formed the basis of significant questioning of all witnesses, does not reflect the totality of the ECRG's recommendations and, taken is isolation, is a distortion of the ECRG's position.

4.92. For each of those reasons, the propositions in the each of the final two sentences of paragraph 231 of Counsel Assisting's submissions are not supported by the evidence and ought be rejected. They are an extraordinary and unsubstantiated slur on both Ms Kelly and Ms Dwyer.

Paragraphs 232 and 233

4.93. These submissions repeat the misrepresentation of the position of Dr Corbett and Mr Eltham, and the WMHHB, stated in paragraph 225 of Counsel Assisting's submissions.

4.94. The WMHHB's primary concern was the welfare of the particular patients then in BAC, not the broader cohort of 'adolescents with persistent or severe mental health conditions'. There is no evidence that the fact that alternative services were not developed in the timeframe initially indicated to the WMHHB equated to a lack of safe and appropriate services for BAC patients.

4.95. The submission that updates provided to the WMHHB were 'superficial' is contrary to the evidence and should be rejected.

4.96. The submission that no proper inquiry was made about what services would be available to the BAC cohort and when, was not put squarely to Dr Corbett or Mr Eltham, it is contrary to the evidence and should be rejected.

Paragraph 255

4.97. The Planning Group Recommendations clearly articulate the adoption of certain recommendations of the ECRG and the caveats or qualifications the Planning Group to some of those. The basis for submitting that the Planning Groups' recommendations are 'difficult to discern' is not apparent.

Paragraph 257

4.98. The point of this submission is unclear. No basis is stated as to why the unsuitability of BAC should have been identified in the minutes.

4.99. As previously noted, minutes are not required to, and generally do not, record a Board's deliberations or detailed reasons for decisions made, only the decisions themselves.

Paragraphs 258

4.100. For the same reason, no adverse inference can or should be drawn from the absence of reference to the ECRG in the minutes.

4.101. The ECRG's report was annexed to the Board Paper, the evidence of Dr Corbett and Mr Eltham was that the ECRG report was considered, their evidence as to the report's content and their understanding of it is contrary to the proposition that it was not considered, and the WMHHB's qualified support for closure (which incorporated the ECRG's recommendations as to the need to ensure adequate alternative/wrap-around services for BAC patients), are all contrary to the proposition that the views of the ECRG were not considered.

4.102. In any event, it was not put to Dr Corbett or Mr Eltham that the views of the ECRG were not considered. At most, what was put was that the ECRG's views were not followed.

Paragraph 259

4.103. The proposition that the Agenda Paper was not scrutinised, was not put to Dr Corbett or Mr Eltham nor is it open on the evidence.

4.104. The proposition that the Agenda Paper was plainly inaccurate or misleading was not put to relevant witnesses, in particular Ms Kelly or Ms Dwyer.

4.105. Further, for the reasons outlined, in particular in paragraphs 4.21 to 44.45 hereof, the proposition that the Board Agenda Paper was plainly inaccurate or misleading is contrary to the evidence and should be rejected.

Paragraph 260

4.106. No such proposition was put to Dr Corbett or Mr Eltham.

4.107. No other Board member was called to evidence or required to provide a statement.

4.108. Accordingly any proposition as what reasons may or may not have 'motivated' the WMHHB is speculative.

4.109. The final sentence of this submission again repeats the error of taking a single proposition from the ECRG's report which does not reflect the totality of the ECRG's recommendations and, taken is isolation, is a distortion of the ECRG's position.

Paragraph 261

4.110. This proposition was not put to relevant witnesses and for the reasons outlined earlier herein is not open on the evidence.

4.111. It is notable that the lesser proposition, that the Agenda Paper lacked factual foundation made against Ms Kelly was never put to her. The proposition

then gathers pace to the very grave assertion that 'probably on the presentation of Ms Kelly and Ms Dwyer and on an agenda paper which was inaccurate and misleading', which was never put to either of those witnesses.

4.112. One could hardly imagine a more serious allegation to make against a witness in an executive position and yet despite a lengthy cross-examination, particularly of Ms Kelly, there was nothing gleaned to support such an allegation nor was the proposition put.

4.113. There is no explanation as to why the allegation gathers in seriousness and yet is still posited as a 'probability' only as against both witnesses.

4.114. The submission in paragraph 261 is an extraordinary and unsubstantiated slur on both Ms Kelly and Ms Dwyer.

Paragraph 262

4.115. The proposition that the WMHHB 'appreciated a likelihood that they would cease to receive funding' for BAC was not put to any witness and the submission is not open on the evidence. As for paragraph 261, they are an extraordinary and unsubstantiated slur on both Ms Kelly and Ms Dwyer.

4.116. The submission misrepresents Mr Eltham's email of 9 November 2012. He was clear in his statement[52] that his email was referring to the cessation of funding for a capital project. It had nothing to do with the operational budget for BAC.

Paragraphs 263 to 266

4.117. These paragraphs misconstrue the evidence.

4.118. In particular, Dr Kingswell explained his reasoning in his oral evidence.

4.119. The governance issues related to the reviews of 2003 and 2009 which highlighted it as an issue. The evidence of Ms Kelly and Ms Dwyer was that governance of BAC was an issue of concern and a reason for supporting closure. That the WMHHB may not have held this as a reason for supporting closure is not the entirety of the issue.

Paragraph 268

4.120. These propositions were not put to relevant witnesses.

4.121. They are contrary to the evidence outlined herein.

Paragraph 269

4.122. This submission again distorts the advice of ECRG by taking a single proposition from its report which does not reflect the totality of the ECRG's recommendations and which, taken is isolation, is a distortion of the ECRG's position.

[52] Exh 50 – statement of Timothy Eltham, para 11.13

4.123. The suggestion from Mr Springborg or Dr Cleary that funds could be found for a tier 3 'had they known it was essential' is contrary to the evidence that:

(a) The Redlands project had been cancelled and the funding diverted to other initiatives, decisions taken at the highest level of the Department.

(b) The Department was operating in a constrained fiscal environment.

(c) Relentless petitioning of the Minister by advocates of BAC, including assertions that adolescents' lives would be put at risk, failed to provoke a change of position by the Minister or the Department.

(d) The fact that the new models proposed by Children's Health Queensland are yet still subject to a progressive roll out due to apparent funding constraints.

Paragraphs 262 to 269

4.124. It is correct that the WMHHB did not consider replacing BAC with a similar in-patient or subacute facility. Any inference that this was remiss of the WMHHB ought be rejected. In that regard:

(a) Establishment of an in-patient or subacute facility was a State level matter, the responsibility for which sit with the Department, through the MHAODB and CHQHHS. This is expressly stated in the Planning Group Recommendations.

(b) Funding for such a project was a State level matter, as evidenced by the fact that the Department had funding governance in respect of the Redlands project and the cessation of same, and the fact that the Department had funding and decision making control in respect of the alternative service options developed under the governance of CHQHHS.

(c) A decision had already been taken that the Department's position was not to consider replacing BAC with another similar facility, as is recognised in paragraph 269 of Counsel Assisting's submissions.

(d) WMHHB had no power or authority to establish such an option.

Paragraphs 270 to 277

4.125. Submissions to the effect that the WMHHB ought to have considered or become involved in the development of alternative models of care at the time when the decision was made to close BAC are misconceived.

4.126. The undisputed evidence is that responsibility and governance in relation to the development of alternative models of care rested with CHQHHS not WMHHS.

4.127. Any such submission conflates the issues of the development of alternative service models with the responsibility of WMHHS (which is accepted) for the safe transition of individual patients then at BAC.

4.128. The evidence of Ms Kelly recited in paragraph 274 reflects a correct understanding by them of 'wrap around care'.

4.129. The evidence of Mr Eltham and Dr Corbett in paragraphs 275 and 276 reflects the level of understanding and detail which one would reasonably expect of a non-clinical Board member.