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STATUTORY DECLARATION

I, **Dr William Kingswell** of Herston in the State of Queensland in the state of Queensland do solemnly and sincerely declare as follows:

I set out below my responses to the Requirement to Give Information in a Written Statement issued by the Commissioner on 29 September 2015.

1. Identify all positions and appointments (permanent, temporary, or acting) held by you in Queensland Health for the calendar years 2012-2014.

From 1 January 2012 to 5 June 2014 I held the position of Acting Executive Director of the Mental Health Alcohol and Other Drugs Branch (**MHAODB**).

From 6 June 2014 to 31 December 2014 I held the position of Executive Director of the MHAODB. I continue to hold this position today.

For various dates between 13 December 2014 and 31 December 2014 I also held the position of Acting Deputy Director of the General Health Services and Clinical Innovation Division (**HSCID**).

From 29 September 2014 to 24 October 2014 I also held the position of Acting Executive Director of Medical Services, Princess Alexandra Hospital, Metro South Hospital and Health Services (**MSHHS**).

In my current role as Executive Director of the MHAODB I lead a division of 76 personnel, with an annual budget of about $21.5million. Prior to 1 July 2015, I exercised the powers and functions of the Director of Mental Health (under the *Mental Health Act 2000* (**Act**)) including protecting the rights of patients, facilitating the proper and efficient administration of the Act and advising and reporting to the Minister on any matter relating to the administration of the Act.

I lead and influence policy development and legislative reform to ensure contemporary clinical practice and mental health service delivery in Queensland and support clinical governance activities to promote high quality and safe mental health, alcohol and other drugs services.

2. Supply details of your CV, including qualifications and experience.

I graduated from the University of Queensland with a Bachelor of Medicine, Bachelor of Surgery in 1985. I became a Fellow of the Royal Australian and New Zealand College of Psychiatrists in 1997.

I completed a Masters of Public Health in 2012, again from the University of Queensland. I became a Fellow of the Royal Australasian College of Medical Administrators in 2014.

A true and correct copy of my curriculum vitae [[DBK.001.003.0611]] is Annexure 1 to this statutory declaration.

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Barrett Adolescent Centre (BAC)

3. Between 1999 and 2014, were there any plans to close the BAC and relocate the services that BAC offered to a new adolescent facility?

I am aware that closure of the BAC was considered at a number of points in time. However, I know of only one funded plan to close the BAC and relocate the services that the BAC offered to a new adolescent facility.

This was the Queensland Plan for Mental Health 2007-2017. A true and correct copy of this document [[DBK.001.004.0084]] is Annexure 2 to this statutory declaration. Please also find annexed as Annexure 3 to this statutory declaration a true and correct copy of the Queensland Plan for Mental Health 2007-2017 Four Year Report, dated October 2011 [[DBK.001.004.0125]].

This plan included $148 million to deliver 17 capital projects that intended to realise 277 new or redeveloped beds, with a net gain of 146 beds.

4. If so, what were those plans, and, if you know, why did it not happen?

The plan to replace the BAC with a similar facility did not proceed. The project (the Redlands Adolescent Extended Treatment Unit or **RAETU**) had an anticipated practical completion date of June 2012. By September 2012, there were no building approvals, the project was more than 12 months behind schedule and was significantly over budget. At that time, the decision was made to cease the project.

The project had been plagued with problems, with the main one being the identification of a suitable site for the facility. After considering other options, Redlands was eventually chosen as the site for the replacement facility. However, it was subsequently discovered that there were koalas on the site, the lack of adequate drainage was an issue and, as a result, the project had to be re-scoped a number of times to fit the changing potential building footprints.

Dr Tony O'Connell, the former Director-General, made the ultimate decision to cease the project in September 2012. I understand that he took this decision following receipt of a Briefing Note prepared by my team and cleared by me. A true and correct copy of this Briefing Note, dated 16 May 2012, [[DBK.001.001.0032]] is Annexure 4 to this statutory declaration.

As appears from the Briefing Note, it was authored by Dr Leanne Geppert, Assistant Director of MHAODB, cleared by me and the content verified by the Chief Health Officer, Dr Jeanette Young.

As noted in the Briefing Note, the recommendation made by myself and my team to shelve the project was made after consultation with multiple stakeholders including the Health Planning and Infrastructure Division and Queensland Health, with some limited consultation also with the mental health sector and the Intergovernmental Funding and Policy Coordination Unit, Strategic Policy, Funding and Intergovernmental Relations Branch, Queensland Health.

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The capital from this project was redirected to the regional mental health HHF projects, directed at providing additional regional mental health Community Care Unit (**CCU**) beds in Bundaberg, Rockhampton, Toowoomba and the Sunshine Coast and additional beds in regional acute/sub-acute/extended in patient mental health services throughout the State.

5. Which Authorised Mental Health Service (AMHS) was the BAC located within?

The BAC was located within the West Moreton Hospital and Health Service (**WMHHS**).

6. What was the reporting structure for the BAC? Was there a head psychiatrist? If so, to whom did they report? What role did the Director of Mental Health (DMH) play in monitoring the delivery of mental health services from the BAC?

It is my understanding that the BAC was within the governance of the mental health program of the WMHHS from 1 July 2012 and that there were reporting relationships from the BAC to the Executive Director and Clinical Director of the Mental Health Service of WMHHS.

It is my understanding that the Clinical Director of the BAC, Dr Trevor Sadler, reported, for clinical matters, to Dr Terry Stedman, the Clinical Director of the WMHHS and reported, for operational matters, to Sharon Kelly, the Executive Director of Specialist Services.

The DMH is responsible for ensuring the rights of involuntary patients are protected and that assessment care and treatment of persons complies with the *Mental Health Act 2000* (Qld) (**Act**). The DMH did not monitor the delivery of mental health services from the BAC. It is not the DMH's role to monitor the delivery of mental health services.

7. Who was responsible for the operations of the BAC between 2011 and 2014?

My recollection is that from 1 January 2011 to 30 June 2012 the BAC was operated by the Darling Downs and West Moreton Health Service District which was an entity within Queensland Health. On 1 July 2012 the West Moreton Hospital and Health Service (**WMHHS**) was established as a statutory agency separate from the DoH. At this time, the BAC became part of the WMHHS.

8. Who held financial responsibility for the budget allocated to the BAC and the expenditure of the funds? What were the financial delegations? Was that budget for the BAC within the responsibility of the DMH budget, Children's Health Queensland budget or the West Moreton Hospital and Health Service budget? Did financial responsibility for the BAC change over the 2011-2014 financial years? If so, explain the changes.

The budget for the BAC was held by the Darling Downs and West Moreton Health Service District up to 1 July 2012 and, after this time, by the WMHHS. I understand an allocation was made to WMHHS for the operation of the Park Centre for Mental Health. It was based on an historical allocation and would grow in line with CPI or

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changes to awards. The BAC was a small component of the Park Centre for Mental Health. It was an allocation referred to as 'block funding', meaning that it would be provided regardless of the activity produced by the Centre. The actual allocation to the Park Centre for Mental Health and its component services, Extended Treatment, High Secure Inpatient Service, Secure Mental Health Rehabilitation, Forensic Treatment and Rehabilitation Unit, Research, Education and BAC was a matter for the WMHHS.

9. **The BAC offered a state-wide health service (ie BAC could receive adolescents from throughout Queensland depending on need). How was this dealt with in a scheme of district Hospital and Health Service Boards?**

The BAC appears in the original Health Service Agreement. According to the Health Service Agreement, the WMHHS has oversight responsibility for the delivery of an adolescent extended treatment and rehabilitation centre for the State of Queensland.

Accordingly, the service could accept referrals from anywhere in the state.

10. **What were the financial implications for a state-wide facility being located within a Hospital and Health Service district?**

The implication of a state-wide facility being located within a HHS was that that particular HHS was funded to provide the service, and the budget of the WMHHS included a block funded amount of money specifically intended for the BAC.

The corollary of this was that the WMHHS had a much larger mental health budget (per capita) than many other HHS's in the State. Approximately 25% of the WMHHS budget was allocated to mental health. This meant that the WMHHS had an extraordinarily large mental health budget, taking into consideration the population area being served by the WMHHS. The reason for this was the funding provided to WMHHS for the Park Centre for Mental Health, of which the BAC was one element.

11. **What were the financial implications for the BAC being located within the West Moreton Hospital and Health Service district?**

See my response to paragraph 10 above.

12. **What was the process for a treating team seeking additional funds to be spent on health or support services that were not offered within the BAC?**

This is not within my knowledge.

13. **Apart from financial implications, are there any other implications arising from child and adolescent mental health services being located within the Hospital and Health Service districts?**

There are child and adolescent mental health services in all HHS's, predominantly ambulatory services. Bed based services exist in Logan Hospital (10 beds), Royal Brisbane Hospital (8 beds), Lady Cilento Children's Hospital (20 beds consists of 11 adolescent and 9 child), Robina Hospital (8 beds), Toowoomba Hospital (8 beds)

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and Townsville Hospital (8 beds). Altogether there are 62 beds in total and usually less than 75% of these are occupied on any given day.

The implications of having services located within HHS's means that young people can receive services as close as possible to their families and communities and are not reliant on stand-alone psychiatric institutional care hundreds of kilometres from home.

14. To whom did the BAC's psychiatrists report?

It is my understanding that the BAC's psychiatrists reported to the Clinical Director of Mental Health Services at the WMHHS, Dr Terry Stedman.

15. Did they report to the Clinical Director of the AMHS?

Yes, see my response to paragraph 14 above.

16. Did the Clinical Director report to the DMH?

No, the Clinical Director reported to Sharon Kelly, the Executive Director of Specialist Services.

17. Who had authority to take disciplinary action against a Clinical Director, authorised psychiatrist or Queensland Health staff?

The responsibility for managing Queensland Health staff including Clinical Directors, and including taking disciplinary action against staff, sat with the District Health Service and later the HHS. However, the DoH maintains a Human Resource Division and is available to assist and support HHS's in this function.

Serious matters would be escalated within the Department so that the Director-General of the Department would have knowledge of significant disciplinary matters within the Department.

18. What "metrics" were used to determine the occupancy of the BAC? If a patient was on overnight leave from the BAC (but not discharged from the BAC) was their overnight absence from the BAC still counted towards occupancy? If not, why was it not counted having regard to the fact that patient was returning to the BAC and the bed could not be used for a new incoming patient?

This is not within my knowledge.

Decision to Close BAC

19. Supply details of any meetings, contact, telephone discussions, written communication and correspondence (including electronic) you had regarding the decision to close the BAC.

I would have had numerous conversations about this with the CEO WMHHS, the Executive Director Mental Health WMHHS, the Clinical Director WMHHS, Director of

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Strategy for Mental Health and Specialised Services, staff within my office and the Deputy Director General HSCID. Not all of those conversations will have resulted in a note.

I cannot now recall the specifics of these discussions.

It was not my place to have discussions with the Minister or his staff unless invited. Having reviewed my emails I recall that I met with the Deputy-Director General on or around 4 September 2012 and that, in respect of the BAC, my advice was that the BAC should be closed and replacement services developed.

I also attended the Barrett Adolescent Stakeholder Meeting on 15 November 2012 together with other representatives of the MHAODB, representatives of the WMHHS, Children's Health Queensland and several other Hospital and Health Services. The purpose of this meeting was to develop an alternative model or models of service to replace the services provided by the BAC.

I was also a member of the West Moreton Planning Group (**Planning Group**) and participated in meetings of the Planning Group.

20. Without limiting paragraph 19 above, in relation to the decision to close the BAC:

(i) Who made the decision to close the BAC?

The decision to close the BAC was ultimately made by the Minister. I expect that the Minister would have made the decision in consultation with the Director-General and the WMHHS Board.

(ii) Who recommended the BAC be closed?

The Planning Group recommended that the BAC be closed, taking into account the findings of the Expert Clinical Reference Group (**ECRG**). The Planning Group included Sharon Kelly, Dr Leanne Geppert, Dr Trevor Sadler, Dr David Hartman and Chris Thorburn.

(iii) What was your recommendation or decision with respect to the closure of the BAC?

My view, which I provided to the Planning Group, was that the BAC should be closed.

(iv) Did you have any input into the decision to close the BAC, and, if so, what was that input?

As stated above, my view was that the BAC should close and I provided this view both in the context of my participation in the Planning Group and prior to this, in the context of informal discussions held within the Department which involved the WMHHS.

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(v) What were the reasons for the closure of the BAC?

As I understand it, the Minister acted upon the recommendation of the WMHHS board that the BAC be closed.

I do not know what other information or considerations the Minister took into account when making this decision.
In my view, there were four main reasons that the BAC needed to close. I expressed this view to the other members of the Planning Group.

Firstly, the centre had been operated as a therapeutic community for many years and, as such, it was a highly controversial and, some would argue, outdated, model of care. No other jurisdiction in Australia runs a centre where adolescents are hospitalised for years within a stand-alone psychiatric institution. A number of reviews over the years had recommended that the BAC be reformed or closed and replaced with alternative services but these had not been actioned.

These reviews included the following:

- Barrett Adolescent Centre – Consultation on Aggression and Violence at the BAC, August 2003 [[DBK.001.004.0001]] – a true and correct copy of which is Annexure 5 to this statutory declaration;

- Options Study for Barrett Adolescent Centre at The Park Centre for Mental Health, December 2004 [[DBK.001.004.0050]] – a true and correct copy of which is Annexure 6 to this statutory declaration; and

- 2009 Review of Barrett Adolescent Centre [[DBK.001.004.0124]] – a true and correct copy of which is Annexure 7 to this statutory declaration. I understand that the comments in blue are by Dr Trevor Sadler.

I consider the reason these were not actioned was largely as a result of consumer group and union advocacy, as well as resistance from clinicians involved with the BAC.

Secondly, the BAC had been earmarked for re-development in the Mental Health Plan. As a consequence, no significant upgrade to the building had occurred for many years and the building fabric was deteriorating and unsuitable for a modern mental health service. All other patient amenities on the same site had been completely rebuilt and the balance of the Barrett Centre Buildings demolished in the mid 1990's.

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Thirdly, the Mental Health Plan contained a commitment to deliver a Forensic Mental Health Treatment and Rehabilitation Unit (**FTRU**) on the Park Centre for Mental Health site. This was scheduled to open in late 2013. Once the FTRU was built, mentally ill offenders undergoing a course of rehabilitation would have unfettered access to the entire site, which included the BAC. While it might be thought that the risk posed to the patients of the BAC from patients from the FTRU was unlikely to materialise, were it to materialise, in my view, it was a risk we could not afford to take with the adolescents receiving treatment at the BAC.

[redacted]

(vi) Did you discuss the proposed closure of the BAC with Dr Trevor Sadler? If so, what were those discussions?

I do not recall discussing the proposed closure of the BAC with Dr Sadler other than his possible presence at meetings we both attended. I expect he knew my view that the centre should close.

(vii) Who caused the Expert Clinical Reference Group (ECRG) to be formed?

My recollection is that this was an initiative of WMHHS.

(viii) Who chose the members of the ECRG?

Dr Leanne Geppert was the Director of the Planning and Partnerships Unit of the MHAODB and she agreed to Chair this group. I believe this was an appropriate appointment (although not one I made) as Dr Geppert had visibility over state and national planning tools for mental health services.

The membership of the ECRG was discussed at a meeting I attended in late 2013. At this meeting, the decision was taken that the ECRG should include a multidisciplinary team which was to include expert child and youth psychiatrists. I recall that Dr Michelle Fryer and Dr James Scott's names were mentioned in this context.

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(ix) How were the members of the ECRG chosen?

I was not involved in choosing the members of the ECRG. I expect this would have been a collaborative effort between Dr Geppert and the Executive Director of Mental Health of the WMHHS.

(x) What were the terms of reference for the ECRG?

A true and correct copy of the Terms of Reference for the ECRG [[DBK.001.001.0146]] is Annexure 8 to this statutory declaration.

The purpose of the ECRG, as described in the Terms of Reference, was to provide expert clinical advice to promote the development of a contemporary evidence based model of care to meet the needs of adolescent mental health consumers who experience severe and persistent psychiatric symptoms that significantly interfere with social, emotional, behavioural and psychological functioning and development.

My understanding of this was that the ECRG was to provide expert advice on the model of care that would replace the BAC.

(xi) Did you consult with the ECRG?

No I was not part of the ECRG and did not consult with the ECRG.

(xii) Did you have any oversight or monitoring role with respect to the ECRG?

No, I did not have any oversight or monitoring role with respect to the ECRG. The Chair of the ECRG, Dr Leanne Geppert, was employed in my Branch and would normally report to me but did not report to me as regards her involvement with the ECRG.

(xiii) Did you have any input into the material considered by the ECRG?

No.

(xiv) Did you receive a copy of the ECRG report?

Yes.

(xv) If you received a copy of the ECRG report, what action did you take? What were your recommendations following receipt of the ECRG report?

WMHHS established a planning group, known as the West Moreton Planning Group (**Planning Group**) to consider the recommendations of

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the ECRG and report to the WMHHS Board on the recommendations. I was part of the Planning Group (by invitation) and contributed to the Planning Group's meetings. The Planning Group came to an end when a report was provided to the WMHHS Board, outlining our findings, in late 2013.

Transitioning Arrangements from BAC

21. **Supply details of any meetings, contact, telephone discussions, written communication and correspondence (including electronic) you had regarding the transitioning arrangements (including treatment and care plans) for patients of the Barrett Adolescent Centre (both inpatient and day attendees) in the lead up to and following the decision to close the BAC.**

I would have had numerous conversations about this with the CEO WMHHS, the Executive Director Mental Health WMHHS, the Clinical Director WMHHS, Director of Strategy for Mental Health and Specialised Services, staff within my office and the Deputy Director General HSCID. Not all of those conversations will have resulted in a note.

I cannot now recall the specifics of these discussions.

I was involved in the Chief Executive and Department of Health Oversight Committee (**CEO Oversight Committee**) that arose when the minister directed that Children's Health Queensland would manage the delivery of replacement services for BAC consumers. This Committee was tasked with overseeing the implementation of the Statewide Adolescent Extended Treatment and Rehabilitation (**SW AETR**) service options. The SW AETR was the result of the ECRG's deliberations. A true and correct copy of the Terms of Reference for the CEO Oversight Committee [[DBK.001.002.0194]] are Annexure 9 to this statutory declaration. The Terms of Reference identifies the membership of the committee.

The CEO Oversight Committee was Chaired by Dr Peter Steer, CEO of CHQ and attended by multiple other stakeholders including representatives of WMHHS, Townsville HHS and Metro South HHS. The purpose of this meeting was not to consider the circumstances of individuals but rather to oversee the development of new services and consider feedback on the overall progress of the transitioning process.

I was not involved in the clinical care or transition planning of any of the adolescents who were patients of BAC at the time of closure. My Branch was asked to find funding for individuals for additional support as they transitioned to alternative care. This is dealt with further below at paragraph 22(iii).

22. **Without limiting paragraph 21 above, in relation to the transitioning arrangements (including treatment and care plans) for transition clients of the BAC (both inpatient and day attendees) in the lead up to and following the decision to close the BAC:**

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(i) Who was responsible for developing the transition arrangements for the BAC transition clients and what were those transition arrangements?

Dr Anne Brennan and Dr Elisabeth Hoehn were engaged to oversee the clinical decisions made about the transitioning of individuals.

(ii) Who had the monitoring or oversight role for the transition arrangements for the BAC transition clients?

It is my understanding that this was managed within WMHHS.

(iii) What role did you have in the transition arrangements for the BAC transition clients?

I was not involved in the transition at an individual patient level. My role was to provide financial support for the transition arrangements. I recall being contacted by the transition team at various junctures with requests for additional funding to be provided to assist with the transition of individual patients. These requests were granted and the funding required provided.

(iv) Was a deadline date set for the closure of the BAC? If so, what was that date and how was that date determined? Was there any flexibility with respect to the closure date for the BAC? If so, what arrangements were in place for the BAC treating team to seek an extension for a BAC transition client?

I recall that I attended meetings where the closure date for the BAC was discussed. I recall that the intention was to finalise the closure prior to the start of the new school year in 2014.

As I understand it, the reasoning behind this decision was that many of the patients of the BAC would go home for the school holidays. It was thought that the least disruptive option would be to close the BAC during a school holiday period, so that the patients did not return to the BAC only to then be moved as a result of the closure.

I recall that Lesley Dwyer, the Chief Executive of the WMHHS was very keen that the closure proceeded in a timely manner so that the closure caused the least disruption possible for the patients.
I do not know how flexible the closure date was.

(v) Did you liaise, contact or facilitate any arrangements with respect to service providers (government or non-government) who would provide support services to BAC transition clients after they were discharged? If so, what arrangements were made?

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No. I provided money from my Branch budget when requested to support individuals.

(vi) Can you explain what is meant by "wrap around tier-3 service"?

A Tier 3 service is described by the ECRG as an inpatient service for admissions of up to 12 months. The service has links to the usual treating HHS of the young person and also has the capacity for family and group rehabilitation programs, as well as access to education or vocational support.

(vii) For BAC transition clients transferring to another AMHS, who was responsible for ensuring the appropriate receiving AMHS was identified?

The transition team was responsible for this.

(viii) If the receiving AMHS had concerns about the transfer, how were these concerns identified and recorded? How were the concerns of the receiving AMHS resolved?

This is not within my knowledge. I am not aware whether the transition team had an established practice for this. Nor am I aware whether any of the receiving AMHS's raised any concerns.
I was not involved in planning care at an individual patient level and do not know what the processes in place around this were.

(ix) Were there any "tier 3" inpatient hospital beds available within the Queensland public health system available for the BAC transition clients?

At the time of the closure of the BAC there were two Tier 3 beds available at the Mater Hospital. These beds were transferred to the Lady Cilento Children's Hospital (**LCCH**) upon its opening in November 2014 and there are now four Tier 3 beds at the LCCH.

(x) Were any protocols developed within Queensland Health as to how the transfers between AMHS would occur for the BAC transition clients (eg would a new treating team need to be identified and the patient meet with the consultant psychiatrist and other members of the team before the transition was to occur)? If so, explain the details.

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This is not within my knowledge.

(xi) What role did the Director of Mental Health (Qld) have in overseeing the transition arrangements for the BAC transition clients?

The DMH had very little role in overseeing the transition arrangements for the BAC transition clients, as the transition of clients was essentially a clinical issue.

[redacted]

(xii) What role did the Chief Psychiatrist (Qld) have in overseeing the transition arrangements for the BAC transition clients?

The Chief Psychiatrist did not have a role in overseeing the transition arrangements for the BAC transition clients.

(xiii) Were there any arrangements made by Queensland Health with respect to developing service delivery agreements with non-governmental organisations for the purposes of delivering mental health care and associated support services to the BAC transition clients? If so, who were the non-government organisations contacted and what were the arrangements?

My Branch allocated funding (as described above) but was not involved in the negotiation of agreements with service providers. This was handled by at the HHS level.

(xiv) What ongoing feedback or advice did you receive in relation to the progression of the transitioning arrangements for the BAC transition clients?

The progress of the transition was reported to the CEO Oversight Committee, but not at an individual patient level.

(xv) What additional training (if any) was offered, developed or provided to Queensland Health staff who were going to be part of the treating team receiving the BAC transition clients?

This is not within my knowledge.

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(xvi) Did you meet with any of the BAC transition clients or their families/carers in relation to their transition from the BAC?

No.

Future Service Delivery (in lieu of BAC)

23. Supply details of any meetings, contact, telephone discussions, written communication and correspondence (including electronic) you had regarding the future service delivery of mental health services to adolescents in Queensland who previously met the criteria for the delivery of services by the BAC (ie proposed service delivery in lieu of the BAC).

I would have had numerous conversations about this with the CEO WMHHS, the Executive Director Mental Health WMHHS, the Clinical Director WMHHS, Director of Strategy for Mental Health and Specialised Services, staff within my office and the Deputy Director General HSCID. Not all of those conversations will have resulted in a note.

I cannot now recall the specifics of these meetings.

In August 2014 the Queensland Mental Health Commission released its strategic plan for Mental Health and Alcohol and other Drugs. That plan committed the DoH to presenting a Mental Health Drug and Alcohol Services Plan (**Services Plan**). My Branch is on track to deliver to the Minister a Draft Services Plan for consideration in mid-November 2015.

The Plan will be informed by the draft National Mental Health Services Planning Framework, the Drug and Alcohol Clinical Care and Prevention Modelling tool, the mental health plans of NSW and WA, the review of mental health services by the National Mental Health Commission, the work of the independent hospital pricing authority, the work of the ECRG, the work commissioned by my Branch from Qld Centre for Mental Health research, the Time and Motion study by Bushell and Cornish and extensive consultation that we have undertaken in all HHSs.
The Services Plan will consider the needs of adolescents requiring extended mental health care.

24. Without limiting paragraph 23, in relation to the future service delivery of mental health services to adolescents who previously met the criteria for admission at the BAC?

(i) What was Queensland Health's proposed model of service delivery for children and adolescents who previously met the criteria for admission at the BAC?

This is not within my knowledge. This is a question for CHQ.

(ii) Were additional funds allocated to Child and Youth Mental Health Services (CYHMS) across Queensland upon the closure of the

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BAC? How much of the funding for the BAC was re-allocated to CYMHS across Queensland?

The WMHHS identified that BAC had a recurrent budget of approximately $3.9million for health services. The Department of Education spent approximately $1million operating the BAC Special School. The WMHHS transferred all of the $3.9million to CHQ.

The DoH held approximately $2million which was intended for Redlands, had the project been completed. That $2million was allocated to CHQ.

In the machinery of government changes following the 2012 election, the funding for community managed mental health programs was transferred to the DoH from the Department of Communities and Child Safety and Disability Services (**DCCSDS**). That funding included approximately $1million for a program referred to as the Time Out Housing Initiative (TOHI). This was a residential program for youth. The funding was non-recurrent to June 2013. My Branch has refunded that program recurrently. Additional funding has been provided to establish assertive mobile outreach youth services in Rockhampton and Cairns. The current recurrent operating budget for services put in place to respond to the closure of BAC is approximately $8million.

Additionally, $6million in capital funding has been provided to Cairns to develop a Y-PARC (Youth Prevention and Recovery Centre). The HHS is pursuing the relevant development approvals for this Centre. This is a hospital grade build and will deliver at least 6 mental health beds to Cairns. The recurrent funding of approximately $1.5m is yet to be identified.

(iii) **What framework was developed for the delivery of non-specialist mental health care (ie support, care and community access) to adolescents in Queensland at risk and previously in need of a "tier 3" service?**

This is not within my knowledge. This was managed at the HHS level.

(iv) **Were any agreements with non-government organisations entered into for the delivery of these services? If so, what organisations were contacted with a view to providing the delivery of these services? Were any agreements entered into with these organisations?**

This is not within my knowledge. This was managed at the HHS level.

(v) **Was any training in the area of child and adolescent mental health offered, developed or provided to these non-government organisations?**

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This is not within my knowledge.

(vi) **Was any additional training offered, developed or provided for Queensland Health staff in relation to child and adolescent mental health issues upon closure of the BAC?**

Not to my knowledge. DoH provides specialist Child and Youth Mental Health Services in all HHS's.

(vii) **Were there any proposals or plans in place within Queensland Health for the development of a new adolescent extended treatment Tier 3 facility in place of the BAC?**

There have not been plans or proposals to develop a Tier 3 facility as a stand-alone unit following the cessation of the project at Redlands. As noted above, there are currently four Tier 3 beds at the LCCH. The current government made an election commitment to develop a tier 3 service to deliver up to 22 beds and a day program of 20 places in South East Queensland.

(viii) **Did you meet with anyone regarding the future delivery of child and adolescent mental health services with respect to the delivery of services previously offered by the BAC? If so, who did you meet with and what did you discuss? What were the outcomes of these meetings?**

This is addressed in my response to paragraph 23 above.

(ix) **Were any non-governmental residential rehabilitation service organisations contacted to provide additional services to at risk children and adolescents? Was additional funding provided to these organisations? What were the arrangements made with these organisations?**

Yes, approximately $1.3million of new funding was provided. The specifics of the arrangements are not known to me. I do know that Aftercare was contracted to provide residential rehabilitation services in [redacted].

Follow-up after Closure of the BAC

25. **Please provide details of any meetings, contact, telephone discussions, written communication and correspondence (including electronic) you had regarding the treatment and care plans, including the ongoing health and wellbeing of the consumers of the BAC (both inpatient and day attendees) after the closure of the BAC on 26 January 2014.**

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I would have had numerous conversations about this with the CEO WMHHS, the Executive Director Mental Health WMHHS, the Clinical Director WMHHS, Director of Strategy for Mental Health and Specialised Services, staff within my office and the Deputy Director General HSCID. Not all of those conversations will have resulted in a note.

I cannot now recall the specifics of these meetings.

I was aware of the media coverage and the social media criticising the decision to close the BAC. I was aware of the three deaths that followed the closure of the centre.

I contacted or arranged to have contacted all the parents and carers that had been involved in the transition of the BAC transition clients in order to alert them to the planned release of the Report of the investigators into the transition process and advise them that we would provide an advance copy of the report to them ahead of the report's release to the media. I did that ahead of the planned media release of the Report of the investigators into the transition process. I cannot remember much of the detail of these conversations. I do recall that some of the parents had some concerns about the transition process but my impression was that there was more concern expressed to me about the fact that the Report had been leaked to journalists before I had had the opportunity to release the report to the parents.

My further response to this paragraph concerns matters that are confidential.

26. Without limiting paragraph 25 above, following the closure of the BAC:

(i) Did you meet with any of the BAC transition clients or their families/carers? If so, who did you meet and what was discussed?

No.

(ii) Did you receive any advice or feedback into the transition arrangements for the BAC transition clients after the closure of the BAC? If so, what advice or feedback did you receive?

My response to this paragraph concerns matters that are confidential. I have accordingly set it out separately in Annexure 10 to this statutory declaration.

(iii) Did you receive any advice as to the treatment or care plans for the BAC transition clients?

No.

(iv) Who commissioned the Report by Associate Professor Beth Kotze and Ms Tania Skippen that was delivered on 30 October 2014? How were those authors selected? What input did you have into

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the decision to prepare a Report? What was the timeframe set around delivery of the Report?

Associate Professor Beth Kotze and Ms Tania Skippen were appointed as Health Service Investigators pursuant to the *Hospital and Health Boards Act 2011*, by the appropriate delegate, the Deputy-Director General, Dr Michael Cleary.

Dr Cleary had asked for my assistance in identifying appropriate investigators. I asked Dr John Allan, the newly appointed Chief Psychiatrist for a recommendation as to who to appoint as investigators, having regard to his recent experience as Chief Psychiatrist for New South Wales. It was considered important that the investigators be from outside Queensland. Dr Allan recommended Associate Professor Kotze and Ms Skippen.

The decision to prepare a Report and the timeframes for reporting were not decisions made by me.

(v) Who set the Terms of Reference (or Scope and Purpose) of the Report? What input did you have in setting the Terms of Reference?

The Terms of Reference were drafted by the DoH's legal team. I had the opportunity to read the Terms of Reference and provide feedback. I believe that my feedback was limited to correcting an incorrect description of Ms Skippen's qualifications. The policy decisions that informed the drafting of the Terms of Reference were not decisions that I had input into.

(vi) Are you aware of any limitations placed upon Associate Professor Kotze and Ms Skippen?

The Report was required within the time frame set out in the Terms of Reference, being 16 September 2014. The timeframe for their Report is the only limitation placed upon Associate Professor Kotze and Ms Skippen that I am aware of.

As investigators appointed under the *Hospital and Health Boards Act 2011*, and pursuant to the Terms of Reference, Associate Professor Kotze and Ms Skippen had the power to request documents and interview Queensland Health staff if they wished to do so.

(vii) Who made the decision not to interview the BAC transition clients and their families/carers? Was that a decision of the authors?

The investigators had the power to interview any person who they considered might be able to assist. I understand that who was to be

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interviewed as part of the investigation was a decision for the investigators.

(viii) Was the Report only to address issues of governance and oversight of the transition process? Was it to consider the adequacy of the healthcare transition plans for each patient?

The report was to address the issues set out in the Terms of Reference. These are set out in the final Report under the heading "Scope and Purpose".

Under this heading, it is noted that the investigators were to advise with respect to whether the healthcare transition plans developed for individual patients by the transition team were adequate to meet the needs of the patients and their families.

(ix) If the Report was to address the healthcare transition plans for each patient, do you think the patients and families should have been consulted?

I do not have visibility over the material that the investigators had access to. However, I understand there was extensive documentation in existence which recorded the consultation that had occurred between patients of the BAC and their families and that this material was available to the investigators.

(x) How were the concerns of the patients and their families regarding the transition to be taken into account in the preparation of the Report?

This is not within my knowledge and is a question for the investigators.

(xi) Were the authors allowed to access each patient's medical file? Were the authors permitted access to the mental health database CIMHA? Were the authors permitted to speak with staff from the receiving AMHS for each patient?

The investigators had considerable powers under the *Hospital and Health Boards Act 2011* and the Terms of Reference to interview staff of the DoH and the HHSs and request that documents be provided. Any failure to comply was to be reported to Dr Cleary as DoH delegate. I assume that these powers would have been sufficient to allow the investigators access to patient medical files.

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[redacted]

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EXHIBIT 68

General

27. What were the adult patient (forensic) risk issues identified at the Park – Centre for Mental Health that had been identified for patients of the BAC?

A 20 bed extended treatment and rehabilitation unit for forensic patients (**FTRU**) was opened on 1 August 2013 to accept patients from the High Security Inpatient Program. This unit is a step down unit for the further rehabilitation of mentally ill offenders. The pressure on high secure beds in Queensland is such that only those offenders who have carried out the most serious offences, such as murder and attempted murder, are managed through the Park Centre for Mental Health Forensic Program.

28. What caused this to become an issue?

The opening of the FTRU, consistent with the 2007-2017 Mental Health Plan occurred on 1 August 2013. The FTRU is critical infrastructure essential to Queensland Health's ability to manage the growing number of mentally ill offenders in Queensland prisons.

29. Had any incidents occurred between adult patients and the patients from BAC?

I do not know whether any incidents had in fact occurred, but there was a significant risk that they might. The population historically housed on the Park Centre for Mental Health site was a population with enduring mental illness. Mentally ill offenders here are, for the most part, contained to a secure hospital, with some patients able to access a limited amount of leave on and off the campus. The population to be managed in FTRU were all mentally ill offenders found of unsound mind or permanently unfit for trial in relation to very serious offences and not thought well enough to be returned to the community.

30. What functions did the DMH have in overseeing the closure of the BAC and how did that role differ from the Queensland Mental Health Commission and the QMHC Commissioner?

The Director of Mental Health is a statutory role given to an employee of the DoH. It is not a position in the usual sense. The statutory role has been moved a number of times to different positions, either my position (Executive Director Mental Health Alcohol and other Drugs Branch) or the Chief Psychiatrist. The role of the DMH was filled by Chief Psychiatrist, Dr Jagmohan Gilhotra from 20 April 2012 to 27 September 2013 and by me from 28 September 2013 to 30 June 2015. The role of the DMH currently is filled by Dr John Allan, Chief Psychiatrist.

The DMH was not involved in the oversight of the closure. The ED MHAODB was involved as the Department had a policy interest in the development of the replacement services to ensure the response was consistent with State and National planning frameworks.

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The QMHC has a whole of government role to, amongst other things, develop a strategic plan for mental health. The QMHC is not a service provider or a complaints agency and does not plan the provision of services for the DoH to implement.

31. **To your knowledge, did the QMHC Commissioner have a role in the closure of the BAC and the future delivery of services to children and adolescents in Queensland who are at risk?**

Not to my knowledge.

32. **With respect to the decision to stand down Dr Trevor Sadler in September 2013, who made that decision and what were the grounds for that decision? Were you consulted? Did you make any recommendations or have any input into the decision? If so, explain those recommendations and input?**

I had discussions with the Chief Executive of WMHHS, Lesley Dwyer, and knew of her concerns. However, I had no input into the decisions that were made in relation to Dr Sadler.

33. **Outline and elaborate upon any other information and knowledge (and the source of that knowledge) you have relevant to the Commission's Terms of References.**

I have nothing further to add.

34. **Identify and exhibit all documents in your custody or control that are referred to in your witness statement.**

Annexure 1 – Dr Kingswell curriculum vitae;

Annexure 2 – Queensland Plan for Mental Health 2007-2017;

Annexure 3 – Queensland Plan for Mental Health 2007-2017 Four Year Report, October 2011;

Annexure 4 – Briefing Note, dated 16 May 2012;

Annexure 5 – Barrett Adolescent Centre – Consultation on Aggression and Violence at the BAC, August 2003;

Annexure 6 – Options Study for Barrett Adolescent Centre at The Park Centre for Mental Health, December 2004;

Annexure 7 – 2009 Review of Barrett Adolescent Centre (Final Report);

Annexure 8 – Terms of Reference for the ECRG;

Annexure 9 – Terms of Reference for the CEO Oversight Committee; and

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Annexure 10 – Confidential Answers to Questions 25 and 26(ii).

35. And I make this solemn declaration conscientiously believing same to be true and by virtue of the provisions of the *Oaths Act 1867.*

[redacted]

DR WILLIAM KINGSWELL

Signed and declared by the declarant at)
Nambour in the State of Queensland)
this 21st day of October 2015)
before me

[redacted]

Justice of the Peace/Solicitor

[redacted]

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EXHIBIT 68

Dr William John Kingswell

MBBS (UQ), MPH (UQ), FRANZCP, FRACMA

Executive Professional Profile

Highly accomplished senior executive with over 30 years of experience and achievements in health care, specialising in psychiatry. Respected and results orientated leader, with exceptional skills in developing partnerships to promote strategic reforms and improvements within mental health services in Queensland. Expertise in managing organisational change in a complex health system and delivery on government commitments through policy development and administration.

Selected Achievements

- Leading the Health Service and Clinical Innovation Division of 663 personnel, as the Acting Deputy Director-General and providing strategic direction and leadership to a range of portfolio areas to ensure strategies are developed and implemented accordingly
- Spearheaded Queensland's mental health reform agenda, including legislative programs, ensuring alignment with contemporary clinical practice and protection and promotion of patient interests and patient and community safety
- Advisor to the Minister for Health and Director-General Department of Health in relation to mental health incidents, service matters and policy development
- Statutory appointment, Director of Mental Health, Queensland Health 2013
- Creation of Queensland's first Integrated Forensic Mental health Service
- Established and driven significant safety and quality improvement initiatives, including the first Clinical Services Capability Framework for mental health services and Statewide Models of Service Delivery for most elements of integrated mental health services
- Expert advisor to courts, tribunals, health services and the Coroner
- Member Education Committee RANZCP
- Chair and board member of multiple medical and psychiatry committees and institutes including RANZCP Committee for Examinations, Bi-National Forensic Section RANZCP and Griffith University Innocence Project
- Senior lecturer and adjunct senior lecturer Queensland University Department of Psychiatry and School of Criminology and Criminal Justice, Griffith University respectively
- Key note speaker and presenter at state and national conferences in areas of amphetamine stimulants and related disorders, Queensland Plan for Mental Health, suicide and self-harm prevention, forensic psychiatry, law and mental health
- Authored papers, abstracts and reports across an extensive array of medical and psychiatry journals and publications
- Awarded the Royal Australian and New Zealand College of Psychiatrists, inaugural Medlicott Award for research in forensic psychiatry.

Professional Qualifications

- Fellow of the Royal Australasian College of Medical Administrators I 2014
- University of Queensland - Master of Public Health I 2012
- Fellow of the Royal Australian and New Zealand College of Psychiatrists I 1997
- University of Queensland - Bachelor of Medicine, Bachelor of Surgery I 1985.

Specialist Skills

- Expert knowledge of mental health services, forensic psychiatry and related policy development
- Strategic leader in planning, collaboration, implementation, governance and performance management in a range of health care, clinical and corporate environments
- Leader of significant mental health reform within Queensland including development of policy to address equity of access and effectiveness of services
- Leader of divisional state-wide portfolio operations ensuring optimal levels of service within budget parameters.

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Health appointments

Executive Director, Mental Health, Alcohol and Other Drugs Branch Queensland Department of Health	**October 2011 – current**
Acting Deputy Director-General, Health Service and Clinical Innovation Queensland Department of Health	February 2015 – July 2015 *(periodic relief from 2014)*
Director, Mental Health Implementation Team Queensland Department of Health	October 2010 – October 2011
Director, Clinical Reform Mental Health Directorate Queensland Department of Health	October 2009 – October 2010
Acting Senior Director, Mental Health Branch Queensland Department of Health	June 2009 – October 2009
Executive Director, Mental Health Service Southside Health Service District	May 2007 – March 2009
Director of Psychiatry Gold Coast Health Services District	November 2005 – May 2007
Acting Director, Mental Health Queensland Department of Health	June 2005 – September 2005
Director, Integrated Forensic Mental Health Central and Southern Zones Queensland Department of Health	June 2001 – November 2005
Acting Director and **Clinical Director, Community Forensic Mental Health Service** John Oxley Memorial Hospital	August 2000 – June 2001
Deputy Director John Oxley Memorial Hospital	May 1998 – August 2000
Staff Psychiatrist John Oxley Memorial Hospital	May 1997 - July 1998
Visiting Senior medical Officer in Psychiatry Various Correctional Centres	December 1994 – May 1997
Senior Medical Officer Wolston Park Hospital Complex	January 1994 – May 1997
Acting Director and **Senior Medical Officer** Sunshine Coast Community Adult Mental Health Service	May 1993 – January 1994
Queensland Rotational Training Program Nambour General Hospital and Princess Alexandra Hospital	1990 - 1991

Professional Highlights

Executive Director I Mental Health Alcohol and Other Drugs Branch I Queensland Department of Health
October 2011 – current

- Leading division of 182 personnel, budget of $32M. Managed the restructure of the Branch in line with the broader restructure of the department. The workforce was reduced to 68 and the budget more than halved. However, core functions were maintained, most staff achieved an outcome that suited them and no industrial action or significant grievance arose
- Exercise the powers and functions as the Director of Mental Health (via the *Mental Health Act 2000 – the Act*) including protection of rights and care of patients, facilitation of proper and efficient administration of the Act, advising and reporting to the Minister on any matter relating to the administration of the Act and promoting community awareness
- Author the Annual Report of the Director of Mental Health, providing an overview of the administration of the Mental Health Act 2000, key developments which have occurred during the reporting period and key initiatives to progress mental health reform in Queensland
- Provide leadership, expert advice and direction in relation to high quality clinical service provision and collaborative learning and sharing of best practice
- Direct and oversight of the establishment of the Queensland Mental Health Commission and the review of the Mental Health Act 2000
- Lead and influence policy development and legislative reform to ensure contemporary clinical practice and mental health service delivery
- State wide leadership and support of clinical governance activities to promote high quality and safe mental health, alcohol and other drugs services
- Establish and maintain effective working relationships with Mental Health Executives in all Hospital and Health Services.

Acting Deputy Director-General I Health Service and Clinical Innovation Division I Queensland Department of Health
February 2015 – July 2015 *(periodic relief as Deputy Director-General during 2014)*

- Led division of 663 personnel, budget of $520+M
- Provided strategic direction and leadership to a range of portfolio areas to ensure strategies are developed and implemented accordingly. Portfolio areas include: The Chief Health Officer Branch (including Office of the Principal Medical Officer); Health System Innovation Branch; Mental Health, Alcohol and Other Drugs Branch; Office of the Chief Dental Officer and Office of the Chief Allied Health Officer
- Resolved health system wide issues including critical patient safety investigations and response to significant public health events and natural disasters
- Advised the Director-General on professional and organisational aspects of Queensland's health system
- Oversight and implementation lead for relevant organisational changes resulting from the Hunter Review.

Various roles within the Mental Health Alcohol and other Drugs Branch, Queensland Department of Health, including- Director Mental Health Plan Implementation Team, Director Clinical Reform and Acting Senior Director.
June 2009 – October 2011

- Led the implementation of the Queensland Mental Health Plan 2007-2017 (the Plan). Oversighted the continued distribution of more than $600m over 4 years, including greater than $125m in capital programs. The first phase of the Plan delivered more than 500 staff and greater than 200 new and redeveloped mental health beds throughout Queensland. It was the largest single investment by Queensland government on the reform of mental health services
- Led the development of the Clinical Services Capability Framework for mental health services
- Developed Models of Service Delivery for the elements of integrated mental health services and led a number of reform projects in partnership with Health Service Districts to implement the MOSD, particularly Cairns, Gold Coast and Darling Downs
- Purchased the number and rolled out 1300MHCALL, an ongoing program that will result in a single contact number for mental health services throughout Queensland.

Professional Highlights (continued)

Executive Director Southside Mental Health Service I Southside Health Service District, Queensland Department of Health
May 2007 – March 2009

- Led in this newly established Health Service District that amalgamated the former, Logan, Bayside and QEII hospitals and their catchments, the development of a single service, multi-campus model for mental health services
- Restructured services to ensure teams were established to serve populations within defined geographic boundaries and the end to end journey for patients was managed by a single team
- Delivered efficiencies by eliminating duplication of administrative function across the three campuses.

Director of Psychiatry I Gold Coast Health Services District
November 2005 - May 2007

- Led the clinical reform during a period of considerable change on the Gold Coast
- Led the reform of the teaching program
- Drove assertive targeted recruitment
- Developed partnerships with the Universities, created shared posts and actively contributed the University teaching programs
- Restructured service delivery by assigning clinical teams to geographic catchment areas. Established robust clinical governance
- Drove data led clinical improvement and held teams to account for their outcomes.

Educational Activities

- Member Education Committee RANZCP (current)
- Immediate past Chair Committee for Examinations RANZCP
- Member Committee for Examinations RANZCP (2005-2011)
- Senior Lecturer, University of Queensland
- Senior Lecturer, Griffith University
- Adjunct Senior Lecturer, School of Criminology and Criminal Justice, Griffith University
- Lecturer Forensic Psychiatry Qld RANZCP training program
- Chief Training Supervisor, Wolston Park Hospital (1997-2002)
- Problem Based Learning Tutor Post Graduate Medical Course
- Chair, Organising Committee – 24th Annual Congress ANZAPPL (2004)
- Member Organising Committee – RANZCP Forensic Section Annual Conference (2005)
- Academic Subcommittee coordinator - transcultural component RANZCP academic lecture program for Psychiatric Registrars in training
- Drafted Curriculum Forensic Psychiatry for Basic Training RANZCP
- Member Management Committee - Postgraduate Forensic Mental Health Training Project. Partnership Griffith University and Qld Health to establish, Graduate Certificate, Graduate Diploma and Masters in Forensic Mental Health available to various health disciplines
- Introduced quarterly Continued Medical Education meetings of the Qld Forensic Section (2001)
- Regular participation in in-service training of staff of Queensland Health including Government Medical Officer and other government and non-government organisations in South East Queensland
- Chair, Forensic Section, RANZCP (2001-2005)
- Subcommittee Advanced Training Forensic Psychiatry (2004-2005) –development of formal training program for advanced training in Forensic Psychiatry
- Finalised Bylaws for advanced training in Forensic Psychiatry, binationally (2003).