In the matter of the *Commissions of Inquiry Act 1950*

Commissions of Inquiry Order (No.4) 2015

Barrett Adolescent Centre Commission of Inquiry

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Tania Lyn Skippen, Associate Director of [redacted]

states on:

1. All documents listed in paragraph 11(a) of the statement of Tania Skippen dated 13 November 2015 (the "Statement") were relevant to investigating and reporting on the state-wide transition and health care planning measures undertaken by the relevant Queensland Health service agencies. Each document added information essential to developing a comprehensive picture of measures undertaken.

2. Information from receiving agencies was provided to the reviewers by Ms Kristi Geddes who requested it. I understand that the initial request for information was made by Ms Geddes on or around 15 August 2014 and a further request was made on or around 11 September 2014.

   (a) The majority of the information was provided after the first request and was made available to the reviewers in hard copy and electronically on USBs which were mailed to the reviewers. I had access to all the information received prior to writing the report and recollect that it was provided efficiently to the reviewers by Ms Geddes as she received it. An email from Ms Geddes

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to A/Prof Kotze copying me on the 18 September 2014 notes Ms Geddes had made further requests for information and that responses were being received (Exhibit A).

(b) The information received following the second request formed part of the overall picture of and was of equal importance as the documents received following the initial request. As noted in Paragraph 1(a) above, all documents were essential to developing a comprehensive picture.

(c) I was aware that [redacted] provided general service information to contribute to the review as requested. I am also aware that Ms Geddes was informed by [redacted] that no patient-specific information was able to be provided by the agency as [redacted] The reviewers did however have access to a summary of patient-related information for [redacted] provided by email by [redacted] to [redacted] on 15 July 2014 (Exhibit B). The content of this email confirmed the detail provided in the BAC clinical notes and transition planning documents and on this basis, it was determined that adequate information was available to the reviewers.

3. A list dated 22 August 2014 and titled 'BAC Inpatients and Day Patients as at 6 August 2013' was provided to Ms Geddes and included in the first folder of material received. A/Prof Kotze and I were provided copies of this list. Exhibit A noted in Paragraph 1 (a) above, contains an email from A/Prof Kotze to Kristi Geddes dated 10 September 2014 asking Ms Geddes to clarify who the Care Coordinators and Associate Care Coordinators were as, in some places, the list was unclear about this. I understand that Ms Geddes requested interviews with all Care Coordinators for the

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six patients whose transitional arrangements were subject to detailed review. Also invited to interview were other staff who had key roles in the transitions, including the Clinical Care Transition Panel members. A/Prof Kotze and I interviewed those who had been invited and agreed to be interviewed. The Care Coordinator and Associate Care Coordinator roles were confirmed during the interviews. I can confirm that the individuals interviewed adequately provided information relevant but not limited to the six patients whose transitional arrangements were subject to detailed review.

4. I am not aware of the date that A/Prof Kotze or I would have each individually first sourced the "TRACK" report or three Singh papers as they were part of a body of literature regularly accessed on the topic of transition. The NSW Health statewide child and youth mental health policy unit that A/Prof Kotze and I are employed by, MH-Children and Young People, provides leadership for child and youth mental health clinical practice and in this role routinely collects and analyses national and international literature to ensure NSW has the best available policies and practices in place. The TRACK study and Singh reports comprise only a portion of the literature we have sourced and saved electronically over the years and routinely reference at MH-Children and Young People. A/Prof Kotze brought hard copies of the three Singh papers to my office while we were writing the report together in October 2014 and we referenced these in the report.

5. With respect, the Commission has misunderstood Paragraph 11 of my previous Statement. Assoc Prof Kotze and I searched and reviewed the literature in an attempt to locate any national or international benchmarks as to the practice of transitioning the care of adolescents in mental health services. No national literature was cited in the Report. Background research was done individually and we came together to discuss the literature and write the report. I was aware of the broader Australian quality and safety literature on clinical handover, continuity of care and transitioning. I

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was also aware of the broader Australian mental health literature for example, written by respected Australian clinicians such as Professor Patrick McGorry (AO) and Professor Ian Hickie (AM), which discuss the need for increased investment in a continuum of mental health services to provide seamless care for young people from early intervention through to tertiary level care and which propose models of youth-specific mental health care. Key themes from this literature were also incorporated into the TRACK study. Our Unit, MH-Children and Young People, invited Professor Hickie to speak on the panel of the Youth Mental Health Transitions Forum that we conducted for NSW Mental Health Leaders in 2012 as referenced in my previous Statement in Paragraph 5 (e). I am not aware however of any Australian literature that was available at the time of writing the Report that specifically addressed the aspects of process, models and outcomes of mental health transition applicable to the BAC cohort. The 2010 Singh paper states "... we do not as yet know how to achieve best transitional care...". The body of literature provides general guidance that transition needs to be acknowledged as a period where patients can experience poorer outcomes and specific attention should be given to meeting their needs across this period while they are adjusting to the transition.

6. Ms Geddes was responsible for requesting and following up with agencies to ensure all information relevant to the review was available to me and A/Prof Kotze. Planning for transfer of care/discharge is a core part of any inpatient admission and staff aim to understand both the patient's needs and the services that will best meet those needs. Information about the patient's needs is collected and held in the clinical documentation system. As part of routine practice, inpatient units also actively source information from and develop relationships with key service providers who can partner in the care of patients during their inpatient stay and following transfer of care. As indicated in Paragraph 12 of my earlier Statement, staff all had access to CIMHA (clinical documentation) records. Evidence of BAC staff sourcing and

partnering with key service providers such as disability, health and accommodation services was also found in the clinical records. Regarding information related to the time frames for transitioning, as also noted in Paragraph 12 of my earlier Statement, staff had access to communication which indicated that while closure at the end of January 2014 was being worked towards, BAC would remain open until all patients were transitioned to other appropriate services. An example of this communication is Communique 1 (Exhibit C).

7. I recall that the agreement between me and A/Prof Kotze not to interview BAC teaching staff about the transition was based on the decision that we had sufficient information in the clinical notes and transition documents to be satisfied that each client's educational and/or vocational needs had been planned for. It does not accord with my recollection that this decision was influenced by the timeline for the finalisation of the Report.

8. Planning for transition of a patient from a mental health inpatient facility is conducted by trained clinical staff who consider the mental health, developmental, social, educational/vocational and community support needs of the patient. Transition is led by the clinical team, overseen by the Consultant Psychiatrist, and incorporates information from partner agencies such as Education and considers the needs and wishes of patients and their families/carers. According to the clinical files of BAC patients, it appeared to be usual practice for BAC clinicians to take a comprehensive and collaborative approach to care and transition planning, where the views of partner agencies such as Education were taken into consideration. An example of this is seen in the record of attendees at Intensive Case Work-ups (ICWs) which included relevant BAC clinical team members, clinical team members from other involved community mental health services, Teachers and Guidance Officers from the BAC school and the patient. The

content covered at these interagency meetings included information on school progress, intervention and involvement. BAC clinical file notes and BAC Transition Team Community Integration Plan checklists included plans, actions and people responsible and covered areas including school Personal Education Plans and School, TAFE and alternative schooling options.

9. Interviewing the staff from the receiving agencies would have provided an opportunity to confirm the information found in the written documentation. The timeline for the investigation influenced the decision not to interview receiving agency staff, however I recall that A/Prof Kotze and I jointly came to the view that adequate information was available to us in the 32 folders and it was able to be cross-checked during the interviews with BAC staff.

10. The Clinical Care Transition Panel led by Dr Anne Brennan worked with other BAC clinicians and staff from other services to complete the transitions. "Transition Team" in Paragraph 14 of the Statement refers to the group of people who were involved in the transition of BAC patients to other services. The reference to Transition Team did not reflect the transition of an individual patient. The Panel was a consistent part of the broader team transitioning patients and Vanessa Clayworth was a member of the Panel. The Terms of Reference for the Panel are provided at Exhibit D. I understand that Dr Brennan chaired the Panel meetings, Laura Johnson (BAC Project Officer) provided Secretariat and Vanessa Clayworth (BAC Senior Nurse), Megan Hayes (BAC Occupational Therapist), Susan Daniel (BAC Community Liaison), Carol Hughes (BAC Social Worker) and Kevin Rodgers (Principal BAC School) were invited core members of the Panel. The Terms of Reference also indicate that invited members could also attend as appropriate. An email invitation to core members to join the Panel from Dr Brennan dated 30 September 2013 is found at Exhibit E. Exhibit F provides two examples of "Barrett Adolescent Centre Transition Team"

Community Reintegration Checklists which outline the roles of both core Panel members and other BAC staff such as Care Coordinators and Education Queensland Staff as part of the Transition Team completing the transitional care. Exhibit G contains an email from Mr Kevin Rodgers to Dr Anne Brennan dated 8 October 2013 proposing how Education Staff would be involved on the Panels and noting that "Teachers have no clinical qualification and any comments or recommendations will be of an educational nature only". As the Panel and Care Coordinators were part of the Transition Teams for the six patients whose transitional arrangements were subject to review, I understand Ms Geddes invited these staff to be interviewed. As indicated in Paragraph 3 above, A/Prof Kotze and I interviewed those who were invited and agreed to be interviewed. The following BAC staff were interviewed; Mara Kochardy, Moira Macleod, Brenton Page, Matthew Beswick, Peta-Louise Yorke, Rosangela Richardson, Victoria Young, Susan Daniel (Panel member), Megan Hayes (Panel member) and Dr Anne Brennan (Panel member).

11. As noted in Paragraph 1 above, all documents were relevant to the investigation. The only redundant documents were the duplicates produced as I understand it as a result of sourcing and printing from CIMHA. This was not a limitation to the investigation. Clinical judgement was used in addition to the template tool to confirm that the transition plans developed matched the client profile presented in the suite of clinical documentation. Various documents confirmed completion of the transition items in the template. These included but were not limited to transition plans, clinical notes, email communication between referring and receiving services, written correspondence to and from family members and documents related to brokerage and support services. Interviews confirmed what was found in the written documentation. From reviewing documents including but not limited to Terms of Reference for Committees, Agendas and Meeting Minutes which reflected the Governance arrangements A/Prof Kotze and I were able to determine evidence of

structures and processes that would support transitioning, as outlined on page 11 and 12 of our Report. Other information such as, but not limited to the issues register, clinical notes and email records, was cross referenced with and confirmed the detail provided in the documents related to governance. Service information including but not limited to service descriptions, consumer handouts, intake and referral forms were cross referenced with and confirmed the detail provided in the CIMHA records such as clinical notes and transition plans and in email communication for example that discussed the choice of the receiving service as appropriate to the patients' needs. Documents relevant to sourcing of brokerage funding and additional supports were reviewed and cross checked against records such as clinical notes and transition plans to confirm integration of funding and supports into transition plans.

12. The relevant articles and policies mentioned in Paragraph 15 (d) of my previous Statement refers to the key documents we determined were most useful to refer to in writing the report. These included the *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* and copies of other policies and best practice documents referenced in my previous Statement, which included the *New South Wales Transfer of Care from Mental Health Inpatient Facilities Policy Directive* PD2012_060, National Standards for Mental Health Services 2010, National Practice Standards for the Mental Health Workforce 2013 and the NSW Child and Adolescent Mental Health Competency Framework 2011. As per my Paragraph 19 of my previous Statement, we also considered the guidance provided to clinicians of the West Moreton Hospital and Health Service related to care planning and transition that included clinician roles, tasks and information for clients and parents/carers.

13. "The questions" in Paragraph 15 (d) of the Statement are the Terms of Reference for the Investigation.

14. The draft Report date that relates to these questions was 12 October 2014.

(a) The questions on pages 809 and 813 of Exhibit W of my previous Statement were located in a draft version of the transition summaries entitled 'Qld review client profiles and transition evidence summary_12 October 2014'. Draft versions of the transition summaries and Report included prompts to the reviewers to remember to source or reference additional information. These prompts were in the form of questions or suggestions that more information was required or that clarification was necessary. I recall that the questions for patients were resolved through sourcing and evaluating the information in the 32 folders and discussing it between the reviewers. For example, for the reviewers had made a comment in the 12 October 2014 draft that Another example is that information related to in the 32 folders was again reviewed to resolve the prompts/questions needing to confirm the Once evidence was found, the prompts were removed and in this instance, information was noted in Appendix C of the Report that

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(b) I recall that the "governance paperwork gaps" referred to in the email from me to A/Prof Kotze related to information that we were aware Ms Kristi Geddes had compiled following her meeting with West Moreton Health Service, which included the flow chart. I did not contact Ms Geddes about this, but sourced the information from the Draft Investigation and Report Framework provided by Ms Geddes to us by email on 23 September 2014 and referred to in Paragraph 9 of my previous Statement. The Draft transition summary also notes that at the time we did not have readily to hand the name of the chairperson of one of the committees or the starting date of the project officer for the Transition Panel. I recall that A/Prof Kotze and I decided this gap in governance information was not material to the findings in the Report as there was evidence in the minutes, agendas and schedules that the committee met regularly and the Transition Panel had commenced meeting in early October 2013.

(c) There is no standard length of transition period. Planning for transfer of care/discharge should start as soon as the patient is admitted to the inpatient mental health unit as the purpose of the admission is to provide mental health care and support the patient to return as soon as possible to living in the community, with as little disruption to their life as possible. I recall that A/Prof Kotze and I jointly agreed to consider the transition period in the context of the Report, as the time from which care was fully provided by the BAC through the period of shared engagement to the time when care was fully provided by the receiving service. It is my opinion that transition had been completed at the time of the

(d) I do not recall what "scratching for fillers" referred to but believe it may have related to my inability to readily locate the information previously noted in Paragraph 14 (b) such as the name of the chairperson of a committee and starting date of the project officer.

15. I considered the factors listed in Paragraph 17 (b) of my previous Statement in confirming the six patients whose transitional arrangements were selected for detailed review. The factors included 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 and drug and alcohol misuse. Of the six patients chosen, which reflects the level of need, risk and complexity of their presentation. These patients were The sixth patient whose file was reviewed was I considered that these files represented a suitable sample of the patients with the most complex transition needs.

16. The same folders are referred to in Paragraph 17 (c) and Paragraph 11 (c) of my previous Statement.

17. I recall the following:

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(a) That clinical staff noted it was not conducive to recovery principles to maintain one patient on their own in the BAC as others patients were being discharged and that staff were trying to transition patients smoothly but in a coordinated way to avoid this. Confirmation of destination accommodation for some patients was known quite late in the transition period and so it was anticipated that a sense of urgency and pressure would have been felt by clinical staff in attempting to coordinate transitions in a planned and smooth way that caused as little disruption and distress to all.

(b) Within the time frames taken in transitioning each patient, all individuals were provided at least one reasonable option that was acceptable to patients and their families for each particular care domain such as accommodation, mental health care, education/vocation and community support.

(c) Meeting papers were provided by Children's Health Queensland Hospital and Health Service (CHQHHS) and the West Moreton Hospital and Health Service (WMHHS) for the Governance meetings held between the announcement of the closure and the closure date. Monthly Board Agendas and Minutes were provided by CHQHHS from August 2013 to January 2014 and Board Agenda Papers for BAC items were provided by WMHHS from April/August 2013 to December 2014. I recall that no WMHHS BAC Board Agenda paper was available for January 2014 and no Board Agendas or Minutes were received from WMHHS. I recall that the BAC-specific Agenda papers contained the BAC updates on transition for the Board which was of interest to the reviewers. CHQHHS Chief Executive and Department of Health Oversight Committee meeting papers were available from October 2013 until January 2014; however I recall that no paper was provided for December 2013. The CHQHHS State-wide Adolescent Extended Treatment and Rehabilitation

Implementation Strategy Steering Committee bimonthly papers were available from 9 September 2013 to 28 January 2014 and the January paper noted the next meeting planned was 10 February 2014. The WMHHS Clinical Care Transition Panel Schedule of Panel meetings commencing 15 October 2013 with staff, consumers and parents/carers was provided, along with monthly Status Reports from October 2013 to January 2014.

(d) I recall that cross membership of committees was designed to support information flow and examples include: Dr Leanne Geppert, A/Director of Strategy, Mental Health & Specialised Services, WMHHS chaired the weekly BAC update meetings and also attended the bi-monthly Steering Committee meetings and the monthly Oversight Committee meetings; and A/Prof Stephen Stathis, Clinical Director, CYMHS, CHQHHS chaired the Steering Committee meetings and attended the Oversight Committee meetings. I recall that A/Prof Stathis also joined the CHQHHS Board meetings to present agenda items related to the BAC transitions. The reviewers were of the opinion that membership was sufficiently senior at each governance meeting to make the decisions that each group was established under its terms of reference to make.

(e) Paragraph 18 below describes the governance groups and the BAC clinical governance pathways were designed so that information flowed and issues were raised from the most clinically focussed groups, being the Clinical Care Transition Panel, associated Clinical Oversight Meetings and BAC Weekly Update Meetings through to the bimonthly Steering Committee and monthly Oversight Committee and Board meetings.

(f) The Report notes "...whilst the general atmosphere of crisis contributed to the complexity of the situation, it does not appear to have detrimentally affected

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the process of transitional care planning for the patients." The interviews with BAC staff, including Dr Brennan confirmed the stressful atmosphere and that despite this, staff continued in an active way to both plan with patients and their families for transition and provide day to day care to patients.

18. Regarding clinical governance, I understand that clinical issues and risks for individuals were raised on an as needed basis by BAC staff with the BAC Director. There were also weekly case review meetings where these issues could be tabled and discussed and the clinical notes and interviews with staff confirmed that Care Coordinators prepared weekly notes for and attended these meetings, the membership of which included the BAC Director. I understand that throughout the transition period, clinical governance for BAC continued to be provided through the usual WMHHS clinical governance structures, where the pathway for escalation of clinical issues and risks was through to the Director of BAC to the Clinical Director, Mental Health and Specialised Services (Dr Terry Stedman). Exhibit H is an example of Dr Brennan alerting Dr Stedman of [redacted] of a BAC patient [redacted] to address risk. I recall from the email documentation, meeting minutes and interviews that support for transition planning and communication with parents was also provided within WMHHS by Dr Leanne Geppert, A/Director of Strategy, Mental Health and Specialised Services and Ms Sharon Kelly, Executive Director Mental Health and Specialised Services. These three senior positions were also on the membership of the weekly transition planning meetings held on a Wednesday and known by various names such as the BAC Weekly Update meeting and the BAC Transition Care Planning Meeting. I also understand from the interview with Dr Brennan and email communication provided, that Dr Brennan's role was being overseen by Dr Elisabeth Hoehn, Psychiatrist, Child and Youth Mental Health Services, CHQHHS and that Dr Brennan sought daily support and guidance from Dr Hoehn. Minutes also indicate that Dr Hoehn attended the Wednesday transition

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planning meetings and I noted that Dr Hoehn was copied into much of Dr Brennan's and Dr Geppert's email correspondence that I saw. I understand that clinical decisions were made and transitional planning was conducted at this level. I recall that the Children's Health Queensland Hospital and Health Service provided oversight of the following three committees - The State-wide Adolescent Extended Treatment and Rehabilitation (SWAETR) Consumer Transition Panel (also referred to as the Clinical Care Transition Panel) which reported and provided updates to the State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Steering Committee and the Chief Executive and Department of Health Oversight Committee. Clinical Oversight Meetings were also held at BAC as required to provide additional expert clinical advice to the Panel regarding complex transitions. Exhibit I contains two examples of these clinical support and decision-making meetings and the senior clinical expertise represented on the membership from WMMHS, CHQ and the Mental Health, Alcohol and Other Drugs Branch (MHAODB). The reviewers considered the membership of the Committees to have sufficient mental health clinical, leadership and management experience and authority to support the Clinical Care Transition Panel and activate supports and authorise enablers for transition such as brokerage funding and high level support from partner agencies to support transitions. I understand that planning for discharge and transition was commenced prior to the first meeting of the Clinical Care Transition Panel on 15 October 2013. Exhibit J which is the Agenda Paper for the West Moreton Hospital and Health Board Executive Committee Meeting held 16 August 2013 notes that all current consumers and their carers were individually spoken to prior to the public announcement and all consumers had an up to date discharge plan. Exhibit K which is the minutes of the SWAETR Implementation Strategy Steering Committee meeting held 23 September 2013 indicate that BAC staff had commenced the

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process of looking at consumer care plans for the future based on individual clinical care needs.

19. The reviewers considered the published literature I referred to in Paragraph 19 of my previous Statement along with our broader understanding of the literature and guidance on good practice transitions.

20. In my previous Statement I noted that transitioning involved a purposeful, planned, movement of the young person from a child-centred to adult-oriented health care system, taking into account both developmental and illness-specific needs. I consider that the movement of patients from BAC following the closure announcement was in line with this definition.

21. Page 11 of the Report and Paragraph 20 of my previous Statement refer to the plans that were put in place in order to transition each patient. I do not refer to one single document. A picture of the plans that were put in place and evidence of plans that were followed through was developed for each patient through reading the documents provided by the relevant Hospital and Health Services. For the six patients whose transitional arrangements were subject to detailed review, the records were reviewed multiple times, interviews were conducted with BAC staff to confirm the content contained in the 32 folders and summaries were provided in the Report in Appendix C and Appendix D. I understand that WMHHS updated some of the excel spreadsheets entitled 'BAC Transition Team' after the date of closure which provided a summary of transition actions taken and dates. The reviewers were able to confirm the completion of these actions through a review of the documents and the interviews. Examples of documents that confirmed this detail include but are not limited to: discharge summaries, referral forms to other agencies, progress notes, email communication between treating teams, medical charts, allied health reports and summary reports provided by Hospital and Health Services. I recall that progress

notes and CIMHA records were updated regularly by staff and communication and information sharing with receiving agencies was conducted in a timely fashion. All patients had accommodation and supports organised at transition that were identified as meeting their needs for level and type of supervision and support. I recall that

[redacted]

[redacted] I was not involved in the initial selection of the six clients and do not recall who made the decision, however I agreed with the choice. The reviewers decided that adequate time was available to review all patient files including plans for transition and undertake and document a detailed review of transition plans for the six clients referred to in Paragraph 15 above. Additional time would have allowed greater documentation of evidence for all BAC clients not just for those who were subject to detailed review. However, all BAC transition plans were reviewed and the findings of that review were included in the Report.

22. I understood the Terms of Reference for the Investigation to refer to adequacy of the transition plans as relating to the sufficiency of how they met the needs of patients and their families; and the appropriateness of the transition plans as relating to how fitting and suitable the plans were for individual patients, taking into account patient care, patient support, patient safety and service quality. A review of the full range of documentation, with confirmation through interviews with BAC clinicians enabled the

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investigators to answer whether the transition plans were adequate and appropriate. Appendix C and Appendix D of the Report contain a summary of key components of evidence. Each component in Appendix C contributed information to the broader comprehensive picture as to whether the plans were adequate and appropriate. Paragraph 11 of my previous Statement notes that there was very little published literature available at the time of writing the report, on the specific topic of process, models and outcomes of transition for young people transitioning to adult mental health services from child and youth mental health services. A guidance document released in December 2014 by the NSW Agency for Clinical Innovation reinforces this. That document is entitled *Key Principles for Transition of Young People from Paediatric to Adult Health Care* and it notes that "...it is recognised that despite agreement about the importance of effective transitional care, there is little evidence to inform best practice about both the process and what constitutes effective transition. Moreover, evidence when it does exist is often of poor quality." This document is not specific to mental health transitions. As also referenced earlier in Paragraph 5 of this Statement, Singh et al. (2010) who have studied the CAMHS-AMHS transitions in detail over many years note that we do not yet know how to best achieve transitional care. The literature referred to in Paragraphs 21 and 22 of my previous Statement which also reference Paragraph 19 of my previous Statement, was the TRACK study, the three Singh papers, the *New South Wales Transfer of Care from Mental Health Inpatient Facilities Policy Directive,* the *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,* the National Practice Standards for the Mental Health Workforce 2013 and the National Standards for Mental Health Services 2011. The use of protocols alone to effect an appropriate and adequate transition should be used with caution. A recent report commissioned by the Canadian Mental Health

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Commission (2015) entitled 'Taking the Next Step Forward – Building a Responsive Mental Health and Addictions System for Emerging Adults' identifies that taking a view that a simple emphasis on transfer protocols and "connecting the dots" can address the issues for young people moving from youth to adult services is limiting. The *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* was the procedure to be used by BAC clinicians when transitioning patients between mental health services during the period of transition. On this basis it was appropriate to use this to inform the components in the Checklist (Appendix C of the Report). This procedure is not specific to transferring patients from any age-specific mental health service. The procedure aligned with clinician and service practice and standards recommended in the National Standards for Mental Health Services 2010 and the National Practice Standards for the Mental Health Workforce 2013 (which were largely developed from the NSW CAMHS Competency Framework 2011 that I led the development of). The Procedure refers to "consumer's recovery/care/treatment plans". These terms are frequently used interchangeably to describe a plan of action for the mental health care/treatment that is intended to promote a consumer's recovery. A range of items together inform the development of a treatment plan which will in turn inform the transfer process and time frames. A range of these items are noted in Appendix C and include: Mental Health (MH) Act Status; Direct consumer assessment and consultation; Assessment of client future service needs; Review of consumer medical chart; Contact with referring agency and local mental health service; Clinical need and risk taken into account; Length of stay of client was considered; Age of client, demographics and family engagement were considered. In addition, availability of funding to provide comprehensive care and the availability of additional supports

such as housing and disability need to be taken into consideration in treatment planning and transition.

23. Exhibit M contains the National Standards for Mental Health Services 2010 and the National Practice Standards for the Mental Health Workforce 2013.

24. Whether or not the closure date was artificial/administrative or firmly fixed, patients should have only been transitioned if suitable options had been found for them. I was of the view that suitable transition options had been found for BAC patients prior to closure.

25. (a) My previous Statement in Paragraph 25 refers to the principles from the Singh reports and TRACK study referenced in the Report which relate to the period of transition under review and include but are not limited to:

(i) The needs and perspectives of patients are central to the process (including developmental needs):

(ii) Families and carers should be consulted;

(iii) Information transfer to support continuity;

(iv) A period of parallel care/joint working to support relational continuity; and;

(v) Transition planning that supports cross-boundary and team continuity (such as at least one meeting involving the service user and/or carer and a key profession from both CAMHS and AMHS prior to transfer of care).

(b) Information and documents that indicated post-transfer of care by BAC include but are not limited to:

(i) Dr Brennan's letter of appointment (Exhibit N) notes her term of employment as ending 9 March 2014. The Barrett Adolescent Centre Timeline – Key Events entry for 31 January 2014 notes "Dr Anne Brennan continued as WMHHS until March 2014 to finalise all clinical requirements and follow up as required of the BAC patient cohort". The timeline was provided as Exhibit AA in my previous Statement.

(ii) I recall that in her interview Dr Brennan mentioned visiting at least two clients in their new accommodation post the closure. She also noted that on two occasions she made follow-up phone calls to clients and provided reports. In her interview, Dr Brennan referred to the first report which I understand she sent to the Board. I recall seeing this document and it included updates on former BAC patients who were transitioned and positive feedback from some of the patients, but I cannot it locate at this present time. I understand this was the first update report prepared by Dr Brennan following closure. In her interview, Dr Brennan also discussed reporting back a second time and that this was reported on 3 March 2014. In her interview she stated "...I did another ring around and then reported back on that and at that stage everything was good and some kids were doing much better than really I think anybody had ever guessed they might be." I understand that Exhibit O, the Barrett Adolescent Centre Consumers Review 3 March 2014 contains that report. The report notes "Dr Anne Brennan has called the young person or a family member or one of their treating team to ascertain their current level of functioning and to ensure all ex BAC consumers are receiving appropriate level of care in the community. Significant issues are highlighted. Waitlist and Assessment List consumers were reviewed throughout February."

(iii) In an email from Dr Brennan to Dr Leanne Geppert dated 15 January 2014 (Exhibit P) Dr Brennan states " I have been following up with all families of discharged consumers to check on progress and ensure they are happy with new care arrangements."

(iv) Patient files from WMHHS and the receiving districts contained information that indicated that BAC staff had contact post-transfer of care and that staff from involved services were in contact with each other and the patient and family across a period of time. For example, the Report notes that after [redacted] There were other examples of this provided in the Report.

(c) Interviews and files confirmed that there was some BAC staff contact post patient transfer from BAC. In the Report we noted that in at least one instance although BAC staff had planned to be involved for a longer period post-

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transfer of care, prolonging the contact was seen as unsettling for the patient by the receiving service. I recall that the interview with Dr Brennan confirmed the two occasions of follow up post transition of all patients where reports were made, mentioned above in this Paragraph.

26. At the time of preparing my last Statement I had been unable to locate my copy of the PRIME incident reports and therefore could not identify the names of all patients involved. I have since located it. A/Prof Kotze and I did discuss whether having access to the PRIME reports pre and post the BAC closure announcement was relevant to us being able to respond to the Terms of Reference for the Investigation. In considering this, we determined that the scope of our review was limited to whether the transition plans were appropriate and adequate to meet the needs of the patients and their families and that the PRIME reports would not provide evidence of this. The finding that there was an increase in incidents following the closure announcement came from information provided by BAC staff at interview. I cannot provide a quantified degree of increase in incidents following the closure announcement because that was not a relevant requirement for our Terms of Reference, therefore it was not an exercise that we undertook.

27. Transition planning could progress as one or more options were identified for each care component for each patient, including It is uncertain whether having more time would have allowed further options to be found or whether the existence of further options would have improved the transitioning process.

28. "Reasonable" was used in the everyday way to describe a sensible system of care, developed on good judgement.

29. of the six patients whose transitional arrangements were subject to detailed review required brokerage funding. These patients were

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Brokerage for these patients was referenced in the Report in Appendix C and Appendix D. Exhibit Q contains two examples of funding sourced for

30. The optimal period of time for staff overlap should be driven by the patient's needs and preferences and the clinical decision making processes of the clinicians involved. A period of joint working where possible, to ensure relational continuity, is recommended in the literature however I am not aware of literature that recommends a time period for staff overlap. Overlap and joint working by the two mental health teams involved in

Transitioning is a purposeful, planned, movement of patients from one service to another, taking into account both developmental and illness-specific needs. As defined in the *NSW Transfer of Care from Mental Health Inpatient Services – Standard Principles and Procedures 2012*, "transfer of care involves the transfer of professional responsibility and accountability for care of a

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mental health consumer to another person or professional or a combination of professionals". This term is somewhat limited in what it conveys and is more service-focussed than encompassing of broader patient-related aspects however, both terms are frequently used in day to day mental health practice to mean the same thing. The literature I was referring to in Paragraph 31 of my previous Statement included but was not limited to the 2009 and 2010 Singh papers which refer to young people getting lost during transition from CAMHS to AMHS and the TRACK study which refers to young people falling through the CAMHS-AMHS gap. It is my experience that mental health services would not normally fund a family member or carer's flights to enable them to attend a transition planning meeting in person for their young person. Interviews and emails confirmed that staff such as Dr Anne Brennan were working extended hours in order to provide optimal transitional care and communicate regularly with families and consumers. Most commonly, in day to day practice, transitions may be completed across a shorter period of time than was involved in transition and involve fewer visits from referring services than were made during transition. I cannot say what, if anything, would have been done differently if the transitions had occurred under normal circumstances at BAC.

31. (a) I reviewed the information provided in the 32 folders while conducting the review and found some fields in transitional planning documents such as checklists were incomplete. An example of this is found in Exhibit F referenced in Paragraph 10 of this Statement.

(b) Paragraph 32 of my previous Statement notes that information was on occasion missing from the transition form, not that "transitional plan documents" were missing. Paragraph 32 of my previous Statement also notes that the information that was missing from the transition form could be located in other parts of the clinical file.

(c) I was not aware that there was an issue receiving Dr Brennan's emails as I reviewed many written by her amongst all that were provided. Appendix A of the Report which contains the Investigation Document Index, located between pages 13 and 138, identifies multiple emails with Dr Brennan as the author and West Moreton Hospital and Health Service as the provider of the documents.

(d) I am satisfied that the patient files provided to me by West Moreton Hospital and Health Service between April/June 2013 and the closure in January 2014 and the records provided by the receiving Health Services allowed me to undertake the investigation.

32. The patient referred to in Paragraph 33 of my previous statement :

(a)

(b)

(c) Both patients noted above required an array of services to be in place for their needs to be met and their preferences to be taken into account. This was the case when they were living in either No mental health service would have provided for all the comprehensive needs of the patients.

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(d) Each mental health service has criteria for acceptance into the service. In the context of page 10 of the Report and Paragraph 33 of my previous Statement, "threshold to service" refers to meeting the acceptance criteria for the community mental health service. Acceptance criteria vary from service to service but generally public adult mental health services accept referral of consumers aged 18 years and over whom are experiencing a severe and complex mental health disturbance/illness requiring a response from a specialist mental health service.

33. I am not aware of an agreement with regards local support. Ms Kristi Geddes provided the support outlined in my previous Statement in Paragraph 6 (g) and as I stated, this seemed to be a natural division of labour given the explanation of Ms

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Geddes' role provided by Ms Wensley Bitton in the email 14 August 2014 which contained the instrument of appointment and Terms of Reference.

34. An Email from myself to Dr Trevor Sadler in early 2009:

(a) Provided in Exhibit B of my previous Statement and referred to in Paragraph 5 (i) of that Statement, indicates that I had spoken with Ms Valda Dorries, Statewide Professional Leader - Allied Health CYMHS, Queensland Health and had discussed the BAC. I recall that I was working on a NSW Health project which involved estimating care packages for inpatient and ambulatory child and adolescent mental health clients and I sought information from a number of services in Queensland at the time, including from BAC. From what I recall of my discussion with Valda I also understood BAC had completed a service evaluation sometime around 2008.

(b) Transitioning of young patients with complex needs was core business for BAC. Service evaluations can provide advice that supports continuous quality improvement including the refinement of clinical processes and protocols. The evaluation may have made recommendations for good practice transitional care for this vulnerable cohort. I accepted that had such an evaluation taken place and recommendations been made, that learnings would usually have been incorporated into current policies, role descriptions and practices which I had access to.

(c) I was not aware of whether an evaluation had actually taken place. I did not know if such an evaluation if it did occur, related to accreditation.

35. The 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 applies to transfers between mental

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health services and is not age specific. The literature related to transitioning clients from child focussed to adult focussed services can also be applied to transitions between child focussed services. These transitions are usually less complicated as the aspect of transitioning to an adult oriented model is not required. On this basis, the reviewers did not consider additional criteria were required.

36. A/Prof Kotze and I discussed the benefit of interviewing patients and their families with regards the transitional care arrangements and A/Prof Kotze enquired about the same with Ms Kristi Geddes by email on 10 September 2014. I was not copied into a response from Ms Geddes on this issue and understand from a subsequent conversation with A/Prof Kotze that Ms Geddes did not respond in writing to A/Prof Kotze's email. I recall raising the question of interviewing patients and families with Ms Geddes in person when I first visited the offices of Minter Ellison, Brisbane to review hard copies of the files. The dates I first visited were the 22 and 23 September 2014 and I recall that I had the conversation on one of those dates. Ms Geddes reminded me that [redacted] Ms Geddes also reminded me that three Coronial investigations were already underway and these were likely to be distressing to patients and families and suggested we consider that further interviews could be additionally distressing. Ms Geddes indicated that there was information in the 32 folders that reflected the involvement of patients and families in transition planning. A/Prof Kotze and I were guided by Ms Geddes statements and as we reviewed the 32 folders of information, determined that we had adequate detail to respond to the Terms of Reference of the Investigation.

37. I am unable to comment on the broad question of whether there was a lack of alignment between child and youth mental health services and adult mental health

services in Queensland during 2013 and 2014. We did not conduct a scoping study on the alignment of child and youth mental health services and adult mental health services that existed in Queensland between 2013 and 2014 as part of the investigation.

38. All documents referred to in this supplementary witness statement are included in Exhibits A through to Exhibit Q.

All the facts sworn to in this affidavit are true to my knowledge and belief except as stated otherwise.

Sworn by Tania Lyn Skippen on 15 January 2016 at Sydney in the presence of:

A Justice of the Peace, C.Dec., Solicitor

Margaret Lawrence (JP)
Justice of the Peace NSW Reg. No. 123994

Deponent

A J.P., C.Dec., Solicitor

In the matter of the *Commissions of Inquiry Act 1950*

Commissions of Inquiry Order (No.4) 2015

Barrett Adolescent Centre Commission of Inquiry

CERTIFICATE OF EXHIBIT

Exhibit A to Q to the Affidavit of Tania Lyn Skippen sworn on 15 January 2016.

[redacted]

Deponent

[redacted]

A J.P., C.Dec., Solicitor

Margaret Lawrence (JP)
Justice of the Peace NSW Reg. No. 123994

In the matter of the *Commissions of Inquiry Act 1950*

Commissions of Inquiry Order (No.4) 2015

Barrett Adolescent Centre Commission of Inquiry

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A

SKIPPEN, Tania

From: Kristi Geddes
Sent: Thursday, 18 September 2014 2:17 PM
To: KOTZE, Beth
Cc: SKIPPEN, Tania
Subject: RE: Barrett Centre Investigation - interviews [ME-ME.FID2743997]

Hi Beth,

As requested, I've issued further requests for information to the various organisations set out below and am starting to get some responses.

WMHHS have requested further information about the BAC review (2008?) you have referred to below, as the contact we have there (Corporate Counsel) is not aware of one having occurred. She has asked where in the material a reference to such a review is.

I appreciate that you are away for another 2 weeks and may not be able to answer that, so have asked them to respond to the remaining requests in the meantime, but if you are able to shed some light, I'd really appreciate it.

Sorry to bother you on your holiday.

Kind regards,
Kristi.

Kristi Geddes Senior Associate
t +
Minter Ellison Lawyers Watertront Place • 1 Eagle Street • Brisbane • QLD 4000
www.minterellison.com

From: KOTZE, Beth [mailto
Sent: Wednesday 10 September 2014 11:34 am
To: Kristi Geddes
Cc: SKIPPEN, Tania
Subject: RE: Barrett Centre Investigation - interviews [ME-ME.FID2743997]

Dear Kristi
I have now touched base with Tania and this is what we've agreed:

1. Tania will use the 2 days when she comes up in September to finalise the review of the clinical files and to write up the clinical summaries that will be required for the report for all the patients in scope. These will be in the nature of brief over-view of each clinical scenario with particular comment on the documented transition plans.
2. In relation to the care coordinators can you please clarify:
    a. A number of the patients have 2 care coordinator names written beside them on the summary sheet – what does this mean? Was there a principal coordinator and a buddy? Or were there 2 care coordinators with clearly delineated roles? Some names have 'associate cc' written beside them – but in other cases there are 2 names and no difference noted.
    b. Is there a written statement of duties for the care coordinators?
    c. Vanessa Clayworth's name isn't against any of the patients as care coordinator – what was the nature of her role? Was it formalised? If so can we please have a copy of the statement of duties?
    d. What is 'business as usual' transition/discharge practice for the service as articulated in formal policies and procedures? If there is a service transition/discharge policy and procedure? Can we please have a copy?
    e. Were there any specific policies/procedures/statement of duties put in place for the transition coordination for these particular patients? If so can we please have a copy?
3. Re the BAC review (?2008) can we please have any excerpt relevant to the topic of transition/discharge planning? Given the very long length of stay of the service one would expect that this would be a major fieid

have specific details of the extent of her involvement with any particular patients, I've just been advised that she played a key role in the transition planning and would therefore be someone we need to speak with.

In the interests of time, do you think it would be possible to obtain the information you require from the receiving agencies via information requests instead of interviews? If so, if you are able to provide me with a list of the specific information you require, I can attend to those requests and hopefully have the information for you upon your return from leave.

I look forward to hearing from you.

Kind regards,
Kristi.

Kristi Geddes
Senior Associate
Minter Ellison

On 8 Sep 2014, at 5:23 pm, "KOTZE, Beth" < > wrote:

> Thanks Kristi
> If at all possible we need to have the clinicians grouped by patients so that I do all the interviews associated with patient x and Tania does all the interviews associated with patient y.
> If we start with the medical staff and the care coordinators for the 6 patients whose files I reviewed that would be good -
> I've had a look at the ToR again and I think it may be difficult to answer 3.1.2 and 3.1.3 in general and 3.1.4 in particular without talking to the agencies that received the referrals because appropriateness goes to the issue of the capacity and capability at the receiving end and the quality of the communication – I am wondering if some of these interviews could be done by telephone if the staff of these agencies are comfortable and willing to cooperate.
> What do you think?
> Beth
>
> **Associate Professor Beth Kotze**
> **MBBS FRANZCP FRACMA Cert Child Psychiatry MMed (Psychotherapy) MHA (UNSW)**
> **Acting Associate Director, Health System Management**
> **Mental Health and Drug and Alcohol Office**
> **NSW Ministry of Health**
> **Direct Dial:**
> **Address:** **I LMB 961 I NORTH SYDNEY NSW 2059**
> **Email**
> **Website: www.health.nsw.gov.au/mhdao**
> <image003.png>
>
> **From:** Kristi Geddes [mailto
> **Sent:** Monday, 8 September 2014 11:40 AM
> **To:** KOTZE, Beth
> **Subject:** Barrett Centre Investigation - interviews [ME-ME.FID2743997]
>
> Hi Beth,
>
> I hope you had a lovely weekend after your trip up on Friday.
>
> As discussed, I am currently arranging staff interviews for you on Monday, 13 October 2014. You had requested meeting with Dr Brennan, Dr Sadler and then each of the care coordinators for the three deceased patients. In total, that would be 9 witnesses.

B

From:
Sent: Tuesday, 15 July 2014 9:40 AM
To: Sdlo

Subject: FW: Estimates brief
Importance: High

Good morning

Below is some information regarding [redacted] I have requested an update from the Region and anticipate I will receive this within the hour.

I also understand Mr Bill Kingswell from Health is also seeking this information.

Please contact me if you wish to discuss further.

Background

[redacted]

[redacted] **Involvement**

[redacted]

Referral to Mental Health Services:

- On transition from the Barrett Centre, various mental health support options were considered including:

[redacted]

[redacted]

[redacted]

Information relating to [redacted] **on** [redacted]

[redacted]

Support/counselling to the family following [redacted]

- [redacted]

Regards,

From:
Sent: Thursday, 10 July 2014 3:54 PM
To: Sdlo
Subject: RE: Estimates brief:

Hi

In response to your request, I can advise as follows:

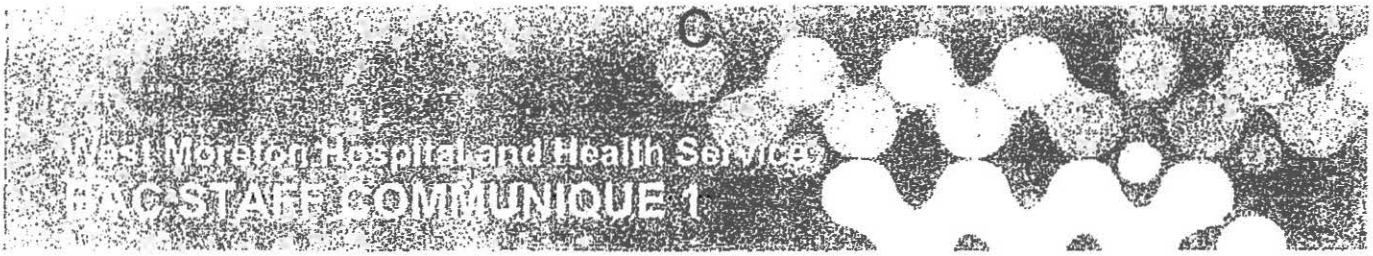
-
-

Is it possible to have a copy of your Estimates Committee brief – in the unlikely event that our Minister receives a question on the topic it would be helpful if they were both on the same page.

Thanks and regards,

From: Sdlo
Sent: Thursday, 10 July 2014 10:11 AM
To:
Subject: Estimates brief:
Importance: High

Thanks for taking my call. We have been



Barrett Adolescent Centre

Welcome to our first Barrett Adolescent Centre Staff Communiqué. I hope this communiqué helps keep you informed about what is happening and how it will impact on yourselves as staff at the BAC.

Barrett Adolescent Centre Building
To provide certainty to both our current consumers and our staff, we continue to work toward the end of January 2014 to cease services from the Barrett Adolescent Centre (BAC) building. This is a flexible date that will be responsive to the needs of our consumer group and as previously stated, will depend on the availability of ongoing care options for each and every young person currently at BAC. The closure of the building is not the end of services for young people. WMHHS will ensure that all young people have alternative options in place before the closure of the BAC building.

Clinical Care Transition Panels
Clinical Care Transition Panels have been planned for each individual young person at BAC, to review individual care needs and support transition to alternative service options when they are available. The Panels will be chaired by Dr Anne Brennan, and will consist of a core group of BAC clinicians and a BAC school representative. Other key stakeholders (HHS's, government departments and NGOs) will be invited to join the Panel as is appropriate to the particular needs of the individual consumer case that is being discussed at the time.

Admissions to BAC
WMHHS is committed to safe and smooth transitions of care for each young person currently attending BAC. These transitions will occur in a manner and time frame that is specifically tailored to the clinical care needs of each individual young person. In order to meet this goal, there will be no more admissions to BAC services from this date forward. For adolescents currently on the waiting list, we will work closely with their referring service to identify their options for care.

Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy
The statewide project for the Adolescent Extended Treatment and Rehabilitation (SW AETR) Implementation Strategy has commenced under the governance of Children's Health Queensland, and the Steering Committee has met three times since 26 August 2013. As part of the statewide project, two Working Groups have been defined to deliver on various aspects of this initiative. Working Group one is the SW AETR Service Options Implementation Working Group, which will build on the work surrounding service models completed by the Expert Clinical Reference Group earlier this year. Working Group two will focus on the financial and staffing requirements of any future service options that are developed.

SW ATER Service Options Implementation Working Group
The SW AETR Service Options Implementation Working Group met for the first time on 1 October 2013 for a half-day Forum. This Forum was attended by a range of multi-disciplinary clinicians and service leaders from Child and Youth Mental Health Services (CYMHS) across Queensland, a BAC staff member (Vanessa Clayworth), a carer representative, and non government organisation (NGO) representation. Feedback suggests that the Forum was a very successful and productive day. A second Forum will be held within the next month to further progress the work on service models. Families and carers have also been invited to provide written submissions on the development of the new service options moving forward for the consideration of this working group.

Date: Thursday, 3 October 2013

Queensland Government

D

Terms of Reference

Statewide Adolescent Extended Treatment and Rehabilitation (SW AETR) Barrett Adolescent Centre Consumer Transition Panel

1. Purpose

The purpose of the SW AETR Barrett Adolescent Centre (BAC) Consumer Transition Panel is to ensure the continuity of care for adolescents currently admitted to the BAC, and support their transition to the most appropriate care option/s that suit their individual needs and are located in (or as near to) their local community.

2. Guiding principles

- The *Health Services Act 1991*
- *Fourth National Mental Health Plan*
- *Queensland Plan for Mental Health 2007-2017*
- *Mental Health Act 2000*

3. Functions

The functions and objectives of the SW AETR Barrett Adolescent Centre (BAC) Consumer Transition Panel include:

- Develop a Transition Plan for adolescents currently admitted to the BAC.
- Develop a Communication Plan for stakeholders, including but not limited to consumers, families, HHSs, education/vocation providers, and other service providers/stakeholders.
- Oversee the discharge process for adolescents currently admitted to the BAC and ensure continuity of care.
- Proactively advocate and support the transition of adolescents, currently admitted to the BAC or on the waitlist, to more appropriate care option/s that suit their individual needs and are located in (or as near to) their local community.
- Define the waitlist group and oversee their individual care, where appropriate/required.
- Facilitate expert discussion and communication from clinician and consumer stakeholders around planning, transition activities.
- Prepare and provide fortnightly Status Reports to the SW AETR Steering Committee, or as required.
- Develop a Risk Mitigation Plan for adolescents currently admitted to the BAC to ensure safe transition to other appropriate care option/s.
- Manage risks associated with the transition of adolescents currently admitted to the BAC, and escalate where resolution is required to successfully transition consumers.
- Provide the Secretariat with information regarding risks, as they arise, for recording and management in the Project Risk Register.

4. Authority

Members are individually accountable for their delegated responsibility, and collectively responsible to contribute to recommendations to the SW AETR Steering Committee.

Decision making capability rests with the Chief Executive and Department of Health Oversight Committee.

5. Frequency of meetings

Meetings will be held on a fortnightly basis, or as required. The Chair may call additional meetings as necessary to address any matters referred to the Panel, or in respect of matters the Panel wishes to pursue within the Terms of Reference.

Attendance can be in-person or via teleconference mediums.

The Panel is life-limited for the duration of development and implementation of SW AETR service options and their transition to CHQ HHS. The Chair will advise Panel members approximately one month prior to the dissolution of the Panel.

6. Membership

Acting Clinical Director, Barrett Adolescent Centre
2 x Barrett Adolescent Centre Clinical Staff
Barrett Adolescent Centre School Representative
Consultant Psychiatrist, High Secure West Moreton HHS
Project Manager, SW AETRS, Children's Health Qld HHS
Project Officer, SW AETRS, West Moreton HHS (as Secretariat)
And as required:
- HHS Northern Representative (as required)
- HHS Central Representative (as required)
- HHS Southern Representative (as required)

Chair:
The Panel will be chaired by the Acting Clinical Director, Barrett Adolescent Centre, or their delegate. The delegate must be suitably briefed prior to the meeting and have the authority to make decisions on behalf of the Chair.

Secretariat:
Secretariat support will be provided by the Project Officer, SW AETRS WM HHS, or an alternate officer nominated by the Chair.

Proxies:
Proxies are not accepted for this Panel, unless special circumstances apply and specific approval is given for each occasion by the Chair.

Other Participants:
The Chair may request external parties to attend a meeting of the Panel. However, such persons do not assume membership or participate in any decision-making processes of the committee.

7. Quorum

As this is not a decision making group, a quorum is not applicable.

8. Performance and Reporting

The Secretariat is to circulate an Action Register to Panel members within three business days of each Panel meeting. Chair will determine the resolution of outstanding action items as they arise.

The Secretariat will coordinate the endorsement of fortnightly status reports, and other related advice to be provided as required, to the SW AETR Steering Committee.

Members are expected to respond to out of session invitations to comment on reports and other advice

within the timeframes outlined by the Secretariat. If no comment is received from a member, it will be assumed that the member has no concerns with the report/advice and it will be taken as endorsed.

9. Confidentiality

Members must acknowledge and act accordingly in their responsibility to maintain confidentiality of all information that is not in the public domain.

10. Risk Management

A proactive approach to risk management will underpin the business of this Panel. The Panel will:

- Identify risks and mitigation strategies associated with the development and implementation of SW AETR service options; and
- Implement processes to enable the Panel to identify, monitor, manage, and escalate critical risks as they relate to the functions of the Panel.

E

From: Anne Brennan

Sent: Monday, 30 September 2013 5:41 PM
To: RODGERS Kevin; Carol Hughes; Megan Hayes; Susan Daniel; Vanessa Clayworth
Cc: Elisabeth Hoehn
Subject: clinical care transition panel

Dear Colleague,
We are forming a clinical care transition panel for each current patient at BAC to plan and facilitate their care as they transition from BAC. For some this will be to other adolescent services, and for others it will be to adult services.
Their complex needs will require a range of supports and services that may involve education,health,housing,disability services,adult guardian and others. These may be public, private or a combination.We will have high level AO support from Laura Johnson
We will commence weekly meetings on Wednesdays on 16 October.
I would like to invite you to be a member of this panel.I am available to discuss any aspect of this plan with you in person,by phone or email.
Thank you for considering this invitation. I look forward to your reply.
Anne

****

F

Barrell Adolescent Centre
- Transition Team -

Barrett Adolescent Centre
- Transition Team -

G

From: Anne Brennan [mailto
Sent: Tuesday, 8 October 2013 4:54 PM
To: RODGERS Kevin
Cc: BLATCH, Peter
Subject: RE: clinical care transition panel

Kevin
We would be happy to invite the Principal Education Officer Student Services in each educational region to the clinical care transition panels.

I am aware that many current young people at BAC will not be continuing education. Education representation on those panels will not be necessary.
I am on leave till Monday 14 October.
Anne

>>> RODGERS Kevin [redacted] 10/8/2013 1:12 pm >>>
Anne

I have spoken to education staff about the clinical care transition panel . Our best way forward given the January date of closure is for the class teachers to attend these meetings and take responsibility for providing a Personal Education Plan for their students which will contain recommendations for an educational transition. Of course until we know where the adolescent will be living we cannot plan.
I will also attend these meetings where I can. In my absence in November Debbie Rankin will attend as acting Principal.
There will be HR implications particularly when there are meetings Tuesday Wednesday and Thursdays. We have extra staff coming in Fridays at the moment for care review which no longer will occur so we will need to rejig days staff come in.
I note that the panel is called a clinical care transition panel. Teachers have no clinical qualification and any comments or recommendations will be of an educational nature only.
As you would be aware most of the adolescents have not had any schooling or educational input for up to two years prior to admission. This makes future educational planning for each student somewhat problematic. Particularly that we have given one term to achieve this. For some adolescents there will be no appropriate educational provision available to them. However it is the responsibility of the Principal Education Officer Student Services in each educational region to recommend the most appropriate placement and we can work through these people to assist in making recommendations.

Kindest regards

Kev Rodgers PSM
Principal
Barrett Adolescent Centre School
From: Anne Brennan
[mailto: [redacted]
Sent: Monday, 30 September 2013 5:41 PM
To: RODGERS Kevin; Carol Hughes; Megan Hayes; Susan Daniel; Vanessa Clayworth
Cc: Elisabeth Hoehn
Subject: clinical care transition panel

Dear Colleague,
We are forming a clinical care transition panel for each current patient at BAC to plan and facilitate their care as they transition from BAC. For some this will be to other adolescent services, and for others it will be to adult services.
Their complex needs will require a range of supports and services that may involve education,health,housing,disability services,adult guardian and others. These may be public, private or a combination.We will have high level AO support from Laura Johnson
We will commence weekly meetings on Wednesdays on 16 October.
I would like to invite you to be a member of this panel.I am available to discuss any aspect of this plan with you in person,by phone or email.
Thank you for considering this invitation. I look forward to your reply.
Anne