In the matter of the *Commissions of Inquiry Act 1950*
Commissions of Inquiry Order (No.4) 2015
Barrett Adolescent Centre Commission of Inquiry

AFFIDAVIT

Jagmohan Gilhotra of the Prince Charles Hospital, Acting Director of Patient Safety, solemnly and sincerely affirms and declares:

1. I have been provided with a Requirement to Give Information in a Written Statement dated 9 October 2015. **Exhibit A** to this affidavit is a copy of this notice.

Professional background

2. I am currently employed as the Acting Director, Patient Safety at the Prince Charles Hospital in Brisbane.

3. Between December 2011 and December 2013, I was employed as the Chief Psychiatrist at Queensland Health.

4. Between April 2012 and September 2013, I was employed as the Director of Mental Health at Queensland Health.

5. Between mid-June 2013 and late August 2013 I was on leave. When I returned from leave I tendered my resignation.

6. Between December 2013 and April 2014 I was employed part-time as a Consultant Psychiatrist at the Toowoomba Hospital.

7. Between January 2014 and March 2015 I was employed part-time as a Consultant Psychiatrist at the Queensland Mental Health Commission.

[redacted] [redacted]

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

AFFIDAVIT

On behalf of the State of Queensland

Crown Solicitor
11th Floor, State Law Building
50 Ann Street
BRISBANE QLD 4000
TEL: [redacted]
Email: [redacted]

8. My current curriculum vitae outlines my full qualifications and employment history. **Exhibit B** to this affidavit is a copy of my current curriculum vitae.

Barrett Adolescent Centre

9. Prior to moving from Sydney to Queensland in 2008, I was not aware of any plans to close the Barrett Adolescent Centre and relocate the services to a new adolescent facility.

10. At some point post 2008, possibly in 2011 or 2012, I became aware of the plans about closing the Barrett Adolescent Centre. To the best of my recollection, I was not involved in any formal discussions relating to the closure of the centre or the relocation of services to a new adolescent facility. In any meetings that I attended where the Barrett Adolescent Centre closure was discussed, my role as Director of Mental Health was to keep in mind compliance with the *Mental Health Act 2000* ("the Mental Health Act").

11. I received a copy of an email on 11 September 2012 from Leanne Geppert to Sharon Kelly suggesting a strategic partnership meeting for the Barrett Adolescent Centre changes. I did not attend that meeting. **Exhibit C** to this affidavit is a copy of that email received at 5:31pm on 11 September 2012 (this email also contains an earlier email from Sharon Kelly dated 11 September 2012 at 2:16pm).

12. On 7 November 2012, I received a copy of an email from Leanne Geppert to Sharon Kelly attaching a draft briefing note to the Director General regarding the closure of the Barrett Adolescent Centre. **Exhibit D** to this affidavit is a copy of this email and draft briefing note received at 4:07pm on 7 November 2012 (this email also contains an earlier email from Sharon Kelly dated 26 October 2012 at 2:46pm).

13. At 12:53pm on 8 November 2012, I received an email from Janet Martin at the Office of the Chief Psychiatrist informing me (and others) that Professor McDermott had told the Child Protection Commission of Inquiry that the Barrett Adolescent Centre would be closing in December. At 2:11pm on 8 November 2012, I forwarded that email to Dr Michael Cleary (cc Dr Bill Kingswell, Leanne Geppert and Sharon Kelly) for their information. **Exhibit E** to this affidavit are copies of these emails.

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14. I have no knowledge of the decision to close the John Oxley Memorial Hospital and build a new High Secure Inpatient Service as that hospital was closed before I came to Queensland in 2008.

15. I am aware that there was a Clinical Director of the Barrett Adolescent Centre who would have reported to the Clinical Director of The Park - Centre for Mental Health ("The Park").

16. The role of the Director of Mental Health in relation to the Barrett Adolescent Centre was to monitor compliance with the Mental Health Act. Between April 2012 and September 2013 that role did not change. I have no recollection of any issues with the Barrett Adolescents Centre's compliance with the Mental Health Act.

17. As far as I am aware, West Morton Hospital and Health Service had operational and financial responsibility for the Barrett Adolescent Centre between 2011 and 2013.The Barrett Adolescent Centre was part of The Park which was in the West Moreton Hospital and Health Service. I had no involvement with operational decisions relating to the Barrett Adolescent Centre.

18. I cannot comment on the budget of the Barrett Adolescent Centre as it was not relevant to my roles.

19. I am not certain how the Barrett Adolescent Centre, as a State-wide health service, was dealt with in the framework of Hospital and Health Services following the introduction of the *Hospital and Health Board Act 2011*.

20. I have no direct knowledge of any financial implications for the Barrett Adolescent Centre, as a State-wide facility, being located within a Hospital and Health Service district. I guess that there would have to have been budget negotiations between the Hospital and Health Service and Queensland Health.

21. As I was not involved in any financial matters, I cannot comment on any financial implications for the Barrett Adolescent Centre being located within the West Morton Hospital and Health Service district.

22. It was my understanding that, following the creation of Hospital and Health Services, the Hospital and Health Service would become self-sufficient in providing and running the

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health services for their communities including child, youth and adolescent mental health services.

23. I did not receive any emails about the changes to Hospital and Health Services. I participated in executive meetings where these changes were discussed at times, including the independence of Hospital and Health Services within the structure of Queensland Health. I do not recall discussing any terms of reference in those meetings.

24. I have no direct knowledge of the details of how the Barrett Adolescent Centre operated under the governance of the West Morton Hospital and Health Service.

25. I have no knowledge of the process for a treating team seeking additional funds for health or support services that were not offered within the Barrett Adolescent Centre. As Director of Mental Health I had no discretion to expend funds. I believe that additional funding would have been negotiated between the West Moreton Hospital and Health Service and Queensland Health.

26. In my view, the main implication arising from child and adolescent mental health services being located within a particular Hospital and Health Service district was the impact or restriction on treating patients close to or within their communities.

27. The Barrett Adolescent Centre psychiatrists reported to the West Moreton Hospital and Health Service through their Clinical Director who reported to the Executive Director of Mental Health at West Moreton Hospital and Health Service.

28. The Clinical Director of the Barrett Adolescent Centre did not report to the Director of Mental Health at Queensland Health.

29. As the Director of Mental Health I did not have any authority to take disciplinary action against clinicians.

30. I am not able to explain the 'metrics' that were used to determine the occupancy of the Barrett Adolescent Centre for reporting purposes. My only role in patients' overnight absences as Director of Mental Health was to monitor the leave of patients where the patient was subject to an order from the Mental Health Court or Mental Health Review Tribunal granting the patient limited community treatment under the Mental Health Act.

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The decision to close the Barrett Adolescent Centre

31. I do not recall participating in any meetings or discussions regarding the decision to close the Barrett Adolescent Centre. However, I have a copy of an email dated 26 October 2012 at 4:46pm from Sharon Kelly (part of **Exhibit D**) that indicates that I may have attended a meeting on 25 October 2015 with Dr Bill Kingswell and Leanne Geppert where the Barrett Adolescent Centre was discussed. If I did attend, my role in that meeting, as Director of Mental Health, would have been to keep in mind the compliance of Mental Health Act.

32. I was also copied into emails about the closure of the Barrett Adolescent Centre. **Exhibit F** to this affidavit is an email from Sharon Kelly dated 8 November 2012 at 3:32pm. **Exhibit G** to this affidavit is an email from Anna Davis to Leanne Geppert dated 8 November 2012 at 3:39pm with attached summary of key issues and information relating to the closure of the Barrett Adolescent Centre.

33. My knowledge of the Expert Clinical Reference Group, the appointment of its members or its Terms of Reference was gained from some of the emails I was copied into. Specifically, on 18 March 2013 I was copied into an email invitation attaching the Terms of Reference and Project Plan. **Exhibit H** to this affidavit is a copy of this email dated 18 March 2013 (the attachments to this email are not available).

34. I was not involved in the delivery of the Expert Clinical Reference Group report or the preparation of material provided to it.

Transitioning arrangements from Barrett Adolescent Centre

35. I was not involved in any meetings or discussions regarding the transitioning arrangements for patients of the Barrett Adolescent Centre in the lead up to and following the decision to close the Centre.

36. I am unable to provide further information about transitioning arrangements as I was not involved at any level except for being informed of the appointment of Dr Brennan.

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37. I do not know what is meant by 'wrap around tier-3 service'.

38. Whilst I did not have any role in this area, I believe the treating team would have been responsible for ensuring an appropriate receiving Mental Health Service was identified for the Barrett Adolescent Centre transition clients.

39. Whilst I did not have any role in this area, I believe the treating team would have been responsible for identifying and recording concerns of the Mental Health Service who were receiving the transition clients.

40. I am aware that there were adolescent inpatient hospital beds available in other Queensland Hospitals. The management of those beds did not form part of my roles.

41. I am not aware of any protocols developed within Queensland Health as to how the transfers between Mental Health Services would occur for the Barrett Adolescent Centre clients.

42. As the Director of Mental Health, I did not have any role in overseeing the transition arrangements for the Barrett Adolescent Centre transition clients.

43. As the Chief Psychiatrist, I did not have any role in overseeing the transition arrangements for the Barrett Adolescent Centre transition clients.

44. I do not know if there were any arrangements made by Queensland Health with respect to developing service delivery agreements with non-government organisations for the purposes of delivering mental health care and associated support services to the Barrett Adolescent Centre transition clients.

45. I do not recall receiving any feedback or advice in relation to the progression of the transitioning arrangements for the Barrett Adolescent Centre transition clients.

46. I do not know 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 Barrett Adolescent Centre transition clients.

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47. I did not arrange any meetings with any of the Barrett Adolescent Centre clients, their families or carers in relation to their transition. An email trail, dated between 8 December 2012 and 9 December 2012, indicates that I did attend a Minister's meeting with the consumer group at the Barrett Adolescent Centre in December 2012 as Dr Bill Kingswell was unable to attend. I didn't play any particular role in the meeting except to listen to the group's anxieties and concerns as they were expressed to the Minister. **Exhibit I** to this affidavit are copies of the emails dated between 8 December 2012 and 9 December 2012 between myself, Dr Michael Cleary and Dr Bill Kingswell.

Future Service delivery (in lieu of Barrett Adolescent Centre)

48. I do not recall being involved in any meetings or discussions regarding the future service delivery of mental health services to children or adolescents in Queensland who previously met the criteria for the delivery of services by the Barrett Adolescent Centre.

49. I received copies of emails (**Exhibits F and G**) describing how West Moreton Hospital and Health Service was proposing to deliver services for children and adolescents who previously met the criteria for admission at the Barrett Adolescent Centre which indicated that the patients would be treated near their community. These emails also contained references to previous plans to relocate the Barrett Adolescent Centre to Redlands Hospital.

50. I have no knowledge of and cannot comment on:
    (a) whether additional funds were allocated to Child and Youth Mental Health Services across Queensland upon the closure of the Barrett Adolescent Centre;
    (b) the framework that was developed for the delivery of non-specialist mental health care to adolescents in Queensland at risk and previously in need of a 'tier 3 'service;
    (c) the agreements with non-government organisations entered into for the delivery of services outlined in paragraph (b);
    (d) whether any training in the area of child and adolescent mental health was offered, developed or provided to non-government organisations;
    (e) whether any non-government residential rehabilitation service organisations were contacted to provide additional services to at risk children or adolescents.

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51. I did not 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 Barrett Adolescent Centre.

General

52. I am not aware of any risk issues arising from the Barrett Adolescent Centre having been located on the grounds of The Park. If there were issues relating to the Mental Health Act, I would have been informed.

53. To my knowledge, there were no incidents reported between adult patients and adolescent patients at the Barrett Adolescent Centre.

54. I am not aware of any risk implications identified for patients of the Barrett Adolescent Centre during the planning, development and construction stages of the Extended Forensic Treatment and Rehabilitation Unit located at The Park.

55. In relation to the *Queensland Plan for Mental Health 2007 – 2017* (10 Year Plan):
    (a) I understand that it was developed before my arrival in Queensland in 2008;
    (b) I have no knowledge of and cannot comment on the extent that the Plan impacted upon the future delivery of child, youth and adolescent mental health services in Queensland;
    (c) I have no knowledge of and cannot comment on whether the Plan had any implications for the Barrett Adolescent Centre and the delivery of the services offered by a Tier 3 facility.

56. I had no involvement in the preparation of the Four Year Report that examined the implementation of the 10 Year Plan.

57. I am not aware of any impact that the Four Year Report had upon the future delivery of child, youth and adolescent mental health services in Queensland.

58. I am not aware of any impact that the Four Year Report had on the Barrett Adolescent Centre and the delivery of the services offered by a Tier 3 facility.

59. I did not have any involvement with the creation of a Queensland Health Commission.

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

60. To my knowledge, the Queensland Mental Health Commission and its Commissioner did not have any specific role in overseeing the implementation of the 10 Year Plan.

61. As I understand, the Queensland Mental Health Commission and its Commissioner advocate a whole of government approach to mental health services. They had no direct role in the delivery of services for child, youth and adolescent health services.

62. During my period of employment with the Mental Health Branch at Queensland Health, apart from emails I was copied in to which have already been discussed, I was not aware of consideration given to other alternative models of care for youth and adolescents suffering from severe mental illness, particularly those who might be in need of extended and long-term treatment and care in a Tier 3 facility.

63. I have no knowledge of and cannot comment on the implications that the change in funding arrangements, arising out of the 10 Year Plan, had on the delivery of youth and adolescent mental health support services for a young person when they turned 18 years of age.

64. In my view, a reasonable model of treatment and care for youth and adolescents in Queensland suffering from severe mental illness who need extensive and long-term treatment and care is one which is near the patient's community. This may be provided either in a residential or non-residential setting.

65. As the Director of Mental Health, I did not have any role in overseeing the closure of the Barrett Adolescent Centre.

66. I am not aware whether the Queensland Mental Health Commissioner had a role in the closure of the Barrett Adolescent Centre and the future delivery or services to at risk children and adolescents in Queensland.

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67. I was not consulted about the decision to stand down Dr Trevor Sadler in September 2013. I did not make any recommendations or have any input in the decision making process.

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

Affirmed by Jagmohan Gilhotra on)
24 November 2015 at Brisbane in the)
presence of:)

[redacted]

JUSTICE OF THE PEACE (QUALIFIED) QUEEN'S PRINCE DEPT. OF JUSTICE & ATTORNEY-GENERAL Reg.No.: 118609

[redacted]

A Justice of the Peace, 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

Exhibits A – I to the Affidavit of Jagmohan Gilhotra affirmed on 24 November 2015.

[redacted]

Deponent

[redacted]

A J.P., C.Dec., [redacted]

JUSTICE OF THE PEACE (QUALIFIED) QUEENSLAND GOVERNMENT Reg.No.: 118609 DEPT. OF JUSTICE & ATTORNEY-GENERAL

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

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BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

Commissions of Inquiry Act 1950
Section 5(1)(d)

REQUIREMENT TO GIVE INFORMATION IN A WRITTEN STATEMENT

To: Dr Mohan Gilhotra

Of: c/- Ms Louise Syme, Crown Law, by email to [redacted]

I, the Honourable MARGARET WILSON QC, Commissioner, appointed pursuant to Commissions of Inquiry Order (No. 4) 2015 to inquire into certain matters pertaining to the Barrett Adolescent Centre ("the Commission") require you to give a written statement to the Commission pursuant to sections 5(1)(d) of the *Commissions of Inquiry Act 1950* in regard to your knowledge of the matters set out in the Schedule annexed hereto.

YOU MUST COMPLY WITH THIS REQUIREMENT BY:

Giving a written statement prepared either in affidavit form or verified as a statutory declaration under the *Oaths Act 1867* to the Commission before **Friday 23 October 2015**, by delivering it to the Commission at Level 10, 179 North Quay, Brisbane.

A copy of the written statement must also be provided electronically either by: email at mail@barrettinquiry.qld.gov.au (in the subject line please include "Requirement for Written Statement"); or via the Commission's website at www.barrettinquiry.qld.gov.au (confidential information should be provided via the Commission's secure website).

If you believe that you have a reasonable excuse for not complying with this notice, for the purposes of section 5(2)(b) of the *Commissions of Inquiry Act 1950* you will need to provide evidence to the Commission in that regard by the due date specified above.

DATED this 9th **day of** October **2015**

[redacted]

The Hon Margaret Wilson QC
Commissioner
Barrett Adolescent Centre Commission of Inquiry

SCHEDULE

1. Identify all positions and appointments (permanent, temporary or acting) held by you in Queensland Health, Queensland Mental Health Commission, Mental Health Review Tribunal (Qld) or other positions you held for the calendar years 2012 – 2015.

2. Supply details of your curriculum vitae, including qualifications and experience.

Barrett Adolescent Centre (BAC)

3. During the period 1999 - 2014, were there any plans to close the BAC and relocate the services that BAC offered to a new adolescent facility? If so, what were those plans, and, if you know, why did it not happen?

4. Did the decision to close the John Oxley Memorial Hospital and build a new High Secure Inpatient Service impact on any future plans to relocate the residential programs and services offered by the BAC? If so, what was that impact?

5. What was the reporting structure for the BAC? Was there a head psychiatrist or Clinical Director? If so, to whom did that person report? What role did the Director of Mental Health (DMH) play in monitoring the delivery of mental health services from the BAC? Did that role change over the 2006 – 2014 period?

6. Who held operational responsibility for the BAC during 2011 - 2014? Who held financial responsibility for the budget allocated to the BAC and the expenditure of the funds? What were the financial delegations?

7. 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 or some other budget? If so, explain which one. Did financial responsibility for the BAC change over the 2011 – 2014 financial years? If so, explain the changes.

8. The BAC offered a state-wide health service (i.e. BAC could receive adolescents from throughout Queensland depending on need). How was such a state-wide health service dealt with in a health framework involving district Hospital and Health Service Boards (and formerly Governing Councils) following the introduction of the *Hospital and Health Networks Act 2011 (Qld)*?

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

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

11. What were the implications for the delivery of child, youth and adolescent mental health services across the state of Queensland following the creation of district networks and Governing Councils?

12. How did the BAC properly function and operate in a hospital and health operating environment where responsibility for governance and operations was devolved to local district Hospital and Health Boards and Hospital and Health Services?

13. 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?

14. Apart from financial implications, were there any other implications arising from child and adolescent mental services being located within a particular Hospital and Health Service district?

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

16. Did the Clinical Director report to the DMH?

17. Who held authority to take disciplinary action against a Clinical Director, authorised psychiatrist or Queensland Health staff employed at the BAC? Did this change over the 2011 – 2014 period?

18. Explain the 'metrics' that were used to determine the occupancy of the BAC for reporting purposes? If a patient was on overnight absence 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?

The 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 Barrett Adolescent Centre with:

    i. Ministers;

    ii. Ministerial staff;

    iii. Departmental representatives;

    iv. Staff;

    v. Chief Executives or Executive Directors;

    vi. Clinicians;

    vii. Consultants;

    viii. Board Members; or

    ix. Commissioners

    appointed, employed or otherwise engaged with the following entities:

    i. Queensland Health;

ii. Department of Education;

iii. Department of Communities, Child Safety and Disability Services;

iv. Department of the Premier and Cabinet;

v. Queensland Treasury;

vi. The Park – Centre for Mental Health Excellence;

vii. Barrett Adolescent Centre;

viii. Children's Health Queensland;

ix. Mater Hospital;

x. Queensland Mental Health Commission;

xi. West Moreton Hospital and Health Service;

xii. West Moreton Hospital and Health Service Board;

xiii. Metro South Hospital and Health Service;

xiv. Metro South Hospital and Health Service Board;

xv. Metro North Hospital and Health Service; or

xvi. Metro North Hospital and Health Service Board.

20. Without limiting paragraph 19 above, in relation to the decision to close the Barrett Adolescent Centre:

i. Following the March 2012 State Election, was a decision made about the proposed relocation of the services offered at BAC to a new facility?

ii. If so, who made that decision and what were the reasons for the decision?

iii. Were there any plans developed to build a new facility or to upgrade the BAC?

iv. Did you discuss the proposed closure of the BAC with Dr Trevor Sadler? If so, explain those discussions?

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

vi. Who chose the members of the ECRG?

vii. How were the members of the ECRG chosen?

viii. What were the Terms of Reference for the ECRG?

ix. What was the time frame set for the delivery of the ECRG Report?

x. Did you consult with the ECRG?

xi. Did you have any oversight or monitoring role with respect to the ECRG?

xii. Did you have any input into the material considered by the ECRG?

xiii. Did you receive a copy of the ECRG report and, if so, when?

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

xv. Who recommended or decided that the BAC be closed?

xvi. Did you have any input into the decision to close the BAC, or did you make any recommendations, and, if so, what was that input or recommendation?

xvii. What were the reasons for the closure of the BAC?

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 Barrett Adolescent Centre with:

i. Ministers;

ii. Ministerial staff;

iii. Departmental representatives;

iv. Staff;

v. Chief Executives or Executive Directors;

vi. Clinicians;

vii. Consultants;

viii. Board Members; or

ix. Commissioners

appointed, employed or otherwise engaged with the following entities:

i. Queensland Health;

ii. Department of Education;