

Barrett Adolescent Centre Commission of Inquiry

Submissions on behalf of the Honourable Lawrence Springborg MP

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1 Introduction

- 1.1 The Honourable Commissioner has been appointed to make a full and careful enquiry in an open and independent manner in respect of a number of matters concerning the closure of the Barrett Adolescent Centre (**BAC**) in January 2014.¹
- 1.2 Given Mr Springborg's role in relation to the closure of the BAC, these submissions will focus upon paragraphs 3(a), (b), (c) and (g) and 4 of the terms of reference.

Findings the Commission should make

- 1.3 For the reasons explained in these submissions, the Commissioner is invited to make the following findings:
- (a) It was appropriate in 2012 for the decision to be made to cease the Redlands project.
 - (b) It was appropriate for Mr Springborg, on the basis of the briefings and advice he received, to support the closure of the BAC as proposed by WMHHS, during 2013.
 - (c) It was appropriate for Mr Springborg, on the basis of the briefings and advice he received in late 2013 and early 2014, not to object to the closure of the BAC on 31 January 2014.
 - (d) With respect to the submissions of Counsel Assisting:
 - (i) There are fundamental problems with analysis presented to the Honourable Commissioner by Counsel Assisting.
 - (ii) In particular, the foundational premise of Counsel Assisting's written submissions served on 18 March 2016 – that a BAC-like facility is "needed" in Queensland – is both an incorrect assessment of the evidence, and an incorrect and irrelevant premise from which to consider the issues mandated by the terms of reference. There is a defect in the assessment of the evidence, and in methodology. This undermines Counsel Assisting's analysis of the third "real" issue (the decision-making process), for that analysis is predicated on (and thus distorted by) a prior view that the decision-making must have arrived at the "wrong" result.
 - (iii) Given these fundamental flaws in Counsel Assisting's submissions, the Commissioner should, unfortunately, place little weight upon them.
 - (e) The terms of reference do not require the Commissioner to make recommendations about the future shape of service delivery in Queensland. The Commissioner should not recommend either for or against the provision of an extended inpatient treatment and rehabilitation facility.
- 1.4 In addition to the principal findings set out above, it is submitted that the Commissioner should make the more specific findings identified throughout these submissions.

Plan of the submissions

- 1.5 The submissions are arranged as follows:

¹ *Commissions of Inquiry Order (No 4) 2015.*

- (a) **Part 2:**
 - (i) considers the approach adopted by Counsel Assisting; and
 - (ii) examines the four "real" issues defined by Counsel Assisting in Part A of their submissions, and submits that they do not provide a relevant or appropriate framework through which to analyse and consider the issues the Commissioner is charged to investigate.
- (b) **Part 3** considers the legal framework.
- (c) **Part 4** provides an overview chronology of events.
- (d) **Part 5** examines the sequence of events and processes leading to the decision to close the BAC. It includes a consideration of who had authority to close the BAC, as requested by the Commissioner.
- (e) **Part 6** considers, from Mr Springborg's perspective, the bases of the closure decision.
- (f) **Part 7** considers, from Mr Springborg's perspective, the closure of the BAC in January 2014.
- (g) **Part 8** considers the position today for adolescent extended treatment and rehabilitation services in Queensland, and what, if any, recommendations the Commissioner should make with respect to such services.

2 Approach adopted by Counsel Assisting

Introduction

- 2.1 It is submitted that the Commissioner's task has been made more difficult by the way in which Counsel Assisting chose to conduct the Inquiry, and the way in which Counsel Assisting presented and analysed the evidence in written submissions served on 18 March 2016.
- 2.2 It ought to be uncontroversial that the role of Counsel Assisting this Commission is not to appear as advocate arguing for a particular result. The Commissioner is charged with conducting an open and "independent" inquiry (*Commissions of Inquiry Order (No 4) 2015*, para 3). The role of Counsel Assisting is to "assist" the Commissioner (*Commissions of Inquiry Act 1950* (Qld), s 21). Counsel Assisting must, like the Commissioner, therefore at all times remain independent and impartial.
- 2.3 Counsel Assisting are required to fairly assist the Commissioner to arrive at the truth, to seek impartially to have the whole of the relevant evidence placed intelligibly before the Commission, and to assist the Commissioner with adequate submissions on the evidence to enable appropriate findings to be made on matters falling within the terms of reference. Bias in the presentation of the evidence is impermissible. So much is apparent from the terms of Rule 94 of the *Queensland Barrister's Conduct Rules* (23 December 2011).² That rule in turn reflects the general principle that the position of Counsel Assisting has, in a general sense, been equated with that of a Crown

² Rule 94 requires counsel assisting before a commission of inquiry to comply with, inter alia, rules 82 and 84 as if any person whose conduct is in question before the commission were an accused for the purposes of those rules. Rule 82 provides "A prosecutor must fairly assist the court to arrive at the truth, must seek impartially to have the whole of the relevant evidence placed intelligibly before the court, and must seek to assist the court with adequate submissions of law to enable the law properly to be applied to the facts". Rule 84 provides "A prosecutor must not, by language or other conduct, seek to inflame or bias the court against the accused."

Prosecutor, whose function "is as an officer of the Court to ensure that all evidence, both favourable and unfavourable...is placed before the Court", and which "excludes any notion of winning and losing; his function is a matter of public duty": Peter Hall QC, *Investigating Corruption and Misconduct in Public Office: Commissions of Inquiry - Powers and Procedures* (Law Book Co, 2004) at page 675.³ It is inimical to the proper function of Counsel Assisting for the Inquiry to be conducted by them in a way directed at the achievement of a preconceived objective.⁴

- 2.4 The way in which Counsel Assisting chose to conduct the oral hearings before the Commissioner was not always in accordance with these principles (no doubt this was done inadvertently, and probably because of the considerable time pressures under which Counsel Assisting were required to work, when measured against the volume of material obtained by the Commission). Cross-examination conducted by Counsel Assisting was, often, not adapted to the presentation of the evidence in a balanced way, or adapted to the discovery of the whole truth. The cross-examination of the Chair of the West Moreton Board is one among a number of examples. This was compounded by the selection of topics to be focussed upon during the oral hearings. Perhaps the most striking example of this is the failure of Counsel Assisting to tender all of the relevant documents concerned with the history of the Redlands project, or to engage in a complete or even-handed way with the evidence that existed about the problems attending this project. Other examples of the selective attention to relevant topics are given later in these submissions (see paragraph 2.18 and 2.23 below).
- 2.5 More unfortunate, however, are the written submissions of Counsel Assisting served on 18 March 2016. These submissions do not present the evidence in an intelligible, even handed, or fair way, or in a manner that is adapted to enabling the Commission to arrive at the truth. Instead, as is considered in the discussion immediately following regarding the four "real issues" identified by Counsel Assisting, the written submissions appear to seek to advocate a particular case, and do so by presenting the evidence in a selective, incomplete and in a number of respects, misleading manner. (Again, this feature of the submissions is explicable by the extremely restricted time frame in which Counsel Assisting were compelled to operate).
- 2.6 The foregoing has the consequence that the Commission's task is made much more difficult. The Commission cannot properly give to the submissions of Counsel Assisting, the weight that they otherwise should be accorded. It is submitted that the Commissioner should in fact accord little weight to the written submissions of Counsel Assisting.
- 2.7 From the perspective of Mr Springborg, the most disappointing example of the dislocation of the written submissions from the ordinary role of Counsel Assisting appears in paragraph 204. It is there said, of the Minister's approval of the August 2012 Briefing Note, as follows:

'On the evidence the likelihood is that this was a political decision, made by the Minister without any analysis or balancing of competing demands. Further, the likelihood is that the Minister made the decision without any advice from Queensland Health and without any consideration of the consequences for the 4 cancelled or deferred projects.'

- 2.8 As is discussed further in **Part 5** below (paragraphs 5.84 to 5.105), this remarkable assertion:

³ Quoting from John Sopinka QC, *Commissions of Inquiry* (Carswell, Canada, 1990), Ch 5, in turn quoting from *Boucher v The Queen* [1955] SCR 16, 23 per Rand J (Sup Ct Canada). In Australia, *Subramanian v R* (2004) 211 ALR 1, [54] affirming *R v Puddick* (1865) 4 F&F 497, 499; 176 ER 662, 663 (prosecutors are to regard themselves as "ministers of justice" and should not "struggle for a conviction", primary duty being the attainment of justice rather than securing a conviction).

⁴ *R v Doogan; ex p Lucas-Smith* (2006) 158 ACTR 1, [162] "While the duties of Crown prosecutors and counsel assisting coroners are by no means the same, we accept that both should be guided by the overriding principle that their goal is the attainment of justice rather than the achievement of a preconceived objective".

- (a) was never put to Mr Springborg when he appeared before the Commission to give evidence. He has not been given an opportunity to answer it;
- (b) is not supported by any evidence;
- (c) is contradicted by the contemporaneous documentary evidence;
- (d) for the foregoing reasons, should never have been made;
- (e) is, as well, an emotive slur upon Mr Springborg's conduct, and calculated to bias and inflame; and
- (f) for that further reason, should never have been made (*Queensland Barrister's Conduct Rules*, 23 December 2011, Rule 94 and 84).

The "real issues" identified by Counsel Assisting

- 2.9 Counsel Assisting submit that there are four "real" issues. The first "real" issue is said to be "was there, and is there, a need for a facility like BAC or its proposed replacement at Redlands".⁵ The second related question is said to be whether the BAC cohort can be accommodated in a facility such as the Lady Cilento Acute Adolescent Mental Health Unit.⁶ The third "real" issue is said to be, if there is a need for a facility like BAC or its proposed replacement at Redlands, "how did we get to the point" where there is no such facility?⁷ The fourth issue is whether the transition arrangements were adequate.⁸
- 2.10 There are fundamental problems with first three "real" issues posed by Counsel Assisting. These problems infect and significantly undermine the balance of the submissions.
- 2.11 **First**, the first and second "real" issues have no basis in the Commission's terms of reference.
- 2.12 The terms of reference address: the decision close the BAC, the bases for that decision and any alternative that ought to have been considered (TOR 3(a), (b), (c) and (g)); the adequacy of the transition arrangements and support provided to patients, their families and staff (TOR 3(d), (e), (f) and (h)); and whether any breaches of legislation has occurred (TOR 3(i)).
- 2.13 Nowhere do the terms of reference address the first two "real" issues posed by Counsel Assisting. Those issues are, in fact, irrelevant issues.⁹ They appear to be addressed for forensic reasons, to advance an argument that the decision-making process miscarried, rather than to dispassionately review the evidence relevant to the terms of reference.
- 2.14 Being irrelevant to the terms of reference, the issues are at best a distraction from the issues the Commissioner is required to consider. At worst, they are liable to lead the Commissioner into error by introducing false issues and distorting how the evidence is reviewed. As discussed below, it appears that the consideration of these issues has both led Counsel Assisting into errors of reasoning and influenced their gathering and assessment of the evidence.
- 2.15 **Second**, it is apparent that Counsel Assisting have led themselves into error and introduced bias into the investigative process, by adopting the process of reasoning backwards.

⁵ Submissions of Counsel Assisting, paragraph 2.

⁶ Submissions of Counsel Assisting, paragraph 8.

⁷ Submissions of Counsel Assisting, paragraph 10.

⁸ Submissions of Counsel Assisting, paragraph 12.

⁹ This much is effectively conceded by the headings to Part B (which considers the first issue) and Part C (which considers the second issue) in Counsel Assisting's submissions. Neither heading notes to which paragraph of the terms of reference the part is relevant. In contrast, Parts D, E, F, H, I, J and K all note the relevant paragraphs of the terms of reference. Part C deals with the legal framework, and there is no Part G.

- 2.16 Counsel Assisting first consider whether a BAC-like facility is “needed”. After concluding that it is, they ask how it is we got to the point that no such facility exists. Unsurprisingly given their starting point, Counsel Assisting are extremely critical of the decision-making process: for *ex hypothesis* the wrong outcome has been reached. However, the reasoning process is infected by the conclusion that a BAC-like facility is essential. It necessarily pre-disposes Counsel Assisting to look for flaws in the process, to justify their existing conclusion that the facility was essential. This backward-reasoning approach is inimical to an impartial and fair assessment of the evidence. The lack of impartiality is evident from the emotive language with which Counsel Assisting express the third “real” issue. Rather than objectively stating one issue for consideration by the Commission is the adequacy of the decision-making process, Counsel Assisting ask “*how did we get to the point where no similar extended treatment facility is available to the young people who, before January 2014, would have been treated by the BAC?*”¹⁰
- 2.17 The backward-reasoning approach also biases the investigative process, as it is likely to cause Counsel Assisting to focus on seeking out evidence to support their conclusions on the first two issues while showing little enthusiasm to explore matters inconsistent with those conclusions.
- 2.18 A good example of this bias in process was the failure of Counsel Assisting to meaningfully examine the delay, financial problems and true viability of the Redlands project. Notwithstanding that the key documents around the decision to cease the Redlands project cite these problems, and that Counsel Assisting seek to reject the notion that those problems were sufficient to justify cancellation of the project,¹¹ Counsel Assisting failed to consider or put to witnesses the contemporaneous documents evidencing these problems. Counsel Assisting suggested to Dr Crompton in oral examination that the delay with the project was “nothing extraordinary”, rather than explore the extent of the delay.¹² No one from the Health Infrastructure Branch was called to give evidence about the viability of the Redlands project.¹³ The question of why a project originally scheduled for completion in 2011 was, in 2012, still years away from completion was assiduously ignored by Counsel Assisting.
- 2.19 An example of a failure to impartially assess the evidence is the summary of the expert evidence regarding the necessity of a BAC-like facility set out in Part B of Counsel Assisting’s submissions. As discussed below, Counsel Assisting fail properly to acknowledge the significant expert opinion that is not supportive of such a facility.
- 2.20 As a result, the conclusions of Counsel Assisting on both the first two “real issues” (paragraphs 15, 93, 94 and 116 of Counsel Assisting submissions) and the decision process (issue 3 – paragraph 268 of Counsel Assisting submissions) are infected by confirmation bias and are inherently unreliable.
- 2.21 The correct approach would have been to consider the decision-making process, as required by TOR 3(a)-(c) and (g), without any pre-conceived view as to whether the outcome of that process was correct or incorrect.
- 2.22 **Third**, the weight of expert evidence given before the Commission does not support an extended treatment and rehabilitation inpatient facility of the kind found at BAC or proposed for Redlands. The conclusions of Counsel Assisting on this issue (paragraphs 15, 93 and 94 of Counsel Assisting submissions) should be rejected.

¹⁰ Submissions of Counsel Assisting, paragraph 10.

¹¹ See submissions of Counsel Assisting, paragraphs 188 and 210.

¹² T7-7: 36.

¹³ Late in the hearings the Commission did obtain a statement from Mr Glaister, the Deputy Director General responsible for the Infrastructure Branch. However, Mr Glaister was not asked about Redlands, only about the redevelopment of The Park and EFTRU. It was left to Mr Glaister to volunteer that the koala preservation initiatives threatened the viability of the Redlands project.

- 2.23 The written submissions of Counsel Assisting on this issue¹⁴ inform the Commissioner that there is an accord between the experts to the effect that an inpatient extended treatment facility is necessary. Counsel Assisting's submissions are highly selective in the evidence cited. As will appear, a short analysis of the evidence reveals that:
- (a) the experts whose evidence is cited by Counsel Assisting do not, in the main, positively support the development an extended inpatient treatment facility; and
 - (b) the preponderance of the evidence led is either against or equivocal about such a facility.

Dr James Scott

- 2.24 Counsel Assisting quote Dr Scott's written statement at length as supportive of the BAC model of care.¹⁵ This statement was taken by Counsel Assisting.¹⁶ But in oral evidence Dr Scott recanted his support of the BAC model. Dr Scott's actual evidence as to the desirability of a BAC-like facility was in fact to the opposite effect of that set out in Counsel Assisting's submissions.

- 2.25 When asked by Counsel Assisting whether it remained his view that a Tier 3 facility was necessary, Dr Scott said:¹⁷

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

- 2.26 While Dr Scott agreed there were some young people who could not be managed in a community, he considered this potential 'gap' was being met by the residential rehabilitation facilities in conjunction with the other services currently in existence.¹⁸

- 2.27 Dr Scott was pressed by other counsel on whether he thought there was value in maintaining a Tier 3 facility as recommended by the Expert Clinical Reference Group (**ECRG**). Again, he said:¹⁹

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

- 2.28 In the last sentence quoted above, Dr Scott touches upon a crucial question, ignored by Counsel Assisting, that must be addressed before one can conclude a Tier 3 facility is "needed". That issue is, even assuming that there are some patients for whom a "Tier 3" service would be beneficial, does funding such a service represent a good use of scarce public resources? We consider this further below.

¹⁴ Submissions of Counsel Assisting, paragraphs 14 to 94.

¹⁵ Submissions of Counsel Assisting, paragraphs 16 to 25.

¹⁶ MNH.900.003.0001 at .0001 (EXH.00114): see the table at the start of the statement.

¹⁷ T8-8:30.

¹⁸ T8-12 to T8-13.

¹⁹ T8-27:20-31.

- 2.29 Dr Scott's evidence was hardly supportive of the need for a new extended inpatient facility. An accurate summary of his evidence is that:
- (a) he was undecided about whether there was any value in maintaining an extended inpatient unit;
 - (b) there was no evidence to support the proposition that an extended inpatient unit was of any clinical benefit; and
 - (c) developments in community-based models may be able to fulfil the need formerly fulfilled by the BAC.

RANZCP view: Dr Michelle Fryer

- 2.30 The position of the RANZCP ought to have been given very significant weight by Counsel Assisting. The RANZCP is, after all, the peak professional body for psychiatrists in Australia and New Zealand.²⁰ Dr Fryer confirmed that she consulted widely with her colleagues before providing her report to the Commission. Dr Fryer's report clearly did not favour the BAC model of care. The RANZCP submission was unequivocal, stating that:

*'The protracted admission of adolescents to inpatient facilities is the antithesis of the strategic direction of mental health service delivery in Australia...there is no evidence that long stay adolescent units are effective or cost effective.'*²¹

- 2.31 As to BAC specifically, Dr Fryer's evidence was that the adolescents who had been admitted to BAC might have been able to be cared for in the community, in light of the current practice and evidence base.²²
- 2.32 She said that with a suite of appropriate community services, it was possible that a subacute inpatient facility was unnecessary.²³
- 2.33 The only group that might benefit from an extended inpatient unit was adolescents with severe, treatment-resistant psychosis.²⁴ The number of adolescents in that category was 'extremely small'.²⁵

Dr Stephen Stathis

- 2.34 The view of Dr Stathis, currently the Medical Director of Child and Youth Mental Health Services of CHQHHS is that:
- (a) the evidence base for the inclusion of subacute beds into the extended treatment model is 'limited/non-existent'.²⁶ On the other hand, there is good evidence which supports treatment in the community;²⁷
 - (b) admitting patients into an inpatient facility was fraught with risk for those patients. These risks included exposing vulnerable adolescents to other young people with disturbing behaviour, and dislocation from family and friends;²⁸

²⁰ The Society's motto is, appropriately, "*ex veritate salus*" – out of truth comes health.

²¹ RANZCP Submission (EXH.00144), 3 December 2015.

²² T25-20:30-40, Exhibit 144.

²³ T25-18:1-5.

²⁴ T25-20:40-45.

²⁵ T25-21:10-15.

²⁶ T24-75:1-5.

²⁷ T24-76:40-45.

²⁸ T24-79 to T24-80.

- (c) there are very few dedicated subacute units anywhere in the world.²⁹ Internationally, subacute beds are not the preferred service option for extended treatment for adolescents. Where alternative community options are available, existing subacute beds are being closed;³⁰
 - (d) inpatient admissions in Queensland into acute adolescent inpatient units have fallen over the past year, by 10-15%. He speculated that this could be due to the introduction of the AYMOs or other community based services;³¹
 - (e) caring for adolescents in a community setting was the preferred model of care for the mental health sector generally, and of patients and their carers;³² and
 - (f) since the closure of BAC, there had only been two referrals to the CHQHHS' subacute inpatient beds. A stand-alone unit that catered to such a small cohort of patients would be difficult to staff and manage.³³
- 2.35 Dr Stathis' views should be accorded significant weight. He is a member of the Royal Australian and New Zealand College of Psychiatrists, and has been a child and adolescent psychiatrist, since 2002. Professor Martin described him as an "exceptional child psychiatrist".³⁴ Moreover, Dr Stathis' views are supported by the detailed "Discussion Paper" dated January 2016, prepared over some nine months by CHQ (and, again, largely overlooked in the submissions of Counsel Assisting). This important document is considered further in Part 8 of these submissions.

Professor Brett McDermott

- 2.36 Counsel Assisting's submissions quote Professor McDermott's written statement in support of an extended inpatient facility.³⁵ In truth, Professor McDermott's evidence was very equivocal on this topic.
- 2.37 When asked about the clinical need for extended care, Professor McDermott said that '*people vary in their opinion about the relative merit of extended care and how much we need.*'³⁶ He said that '*no one in the world*' could answer the question.³⁷
- 2.38 This was because the efficacy of the BAC had simply never been evaluated.³⁸ It could have done a fantastic job or not – there was no evidence either way.³⁹ He rejected the proposition that anecdotal evidence in support of the BAC model (proposed by Dr Sadler's Counsel) was probative of anything.⁴⁰
- 2.39 When asked if it would be better for a patient to stay at home without adequate services, or go into a facility like BAC – he said it was a patient by patient decision, and referred to the possibility of telepsychiatry services.⁴¹ He spoke compellingly about the dangers of institutionalisation⁴², and said that a risk associated with long-term in-patient facilities like the BAC was that residents were

²⁹ T24-71:40.

³⁰ T24-70:45.

³¹ T24-72:25-35.

³² T24-79 to T24-80.

³³ T24-71:15-20.

³⁴ T25-43:4

³⁵ Submissions of Counsel Assisting, paragraph 75.

³⁶ T7-44:40-45.

³⁷ T7-65:44.

³⁸ T7-47:30.

³⁹ T7-65:48.

⁴⁰ T7-68:16.

⁴¹ T7-48:38.

⁴² T7-60 to T7-61.

not exposed to extensive modelling of normal behaviour,⁴³ something which would be important to their recovery.

- 2.40 A number of former BAC patients have given evidence consistent with this assessment of risk, including about the deterioration of their family relationship after their admission to BAC,⁴⁴ and the learning of self-harming behaviour from other patients when they were admitted to BAC.⁴⁵
- 2.41 Professor McDermott also said that in Queensland, the potential cohort for an extended in-patient service might be in the order of "3 to 5 [beds] so a small number of individuals".⁴⁶

Professor Padraig McGorry

- 2.42 Professor McGorry gave some evidence in support of a BAC-type facility. However even he said that:⁴⁷
- (a) provided a range of other services were available in the community, the number of adolescents that might require a BAC facility would be 'shrunk considerably'; and
 - (b) there was a lack of evidence about the efficacy of treatment options for this group of patients.

- 2.43 Professor McGorry also acknowledged that:⁴⁸

'I've got a slightly open mind about [the need for a BAC-type facility] in the sense that I've never seen a – a jurisdiction where all of the other elements have been provided so you can't be totally sure that if all those elements like excellent primary care and assertive outreach home-based treatment, Step Up Step Down and – and – and the therapeutic acute unit. If all of those things were there it is possible that you might not have to have this type of unit, ... but I have never seen it.'

- 2.44 In his written statement, Professor McGorry described the closure of BAC as '*irresponsible de-institutionalisation*'. That is an inflammatory description. When asked about it these words, Professor McGorry he conceded that he had used them only on the basis of what Counsel Assisting had told him about the process.⁴⁹
- 2.45 It is apparent, and very unsatisfactory, that Professor McGorry, when preparing his written statement, was not made aware of the new State-wide model of care developed by CHQHHS, and had not spoken with Dr Stathis or Dr Steer about their work to develop that model of care.⁵⁰ Nor was he informed of the opening of EFTRU or the risks that this posed for the patients at the BAC. When his attention was drawn to it in the course of his oral evidence, he acknowledged that the risks of such having such a services co-located could provide a basis for closing BAC.⁵¹
- 2.46 Given the incomplete and inadequate instructions that, unfortunately, Professor McGorry was given, the Commission should give little weight to his evidence on this point.

⁴³ T7-61:45.

⁴⁴ Statement of Anna Edwards (EXH.00163), paragraph 31.

⁴⁵ Statement of [REDACTED] EXH.00169), paragraph 11.

⁴⁶ T7-44:40-50.

⁴⁷ T18-4 to T18-6.

⁴⁸ T18-16:47-T18-17:8.

⁴⁹ T18-15:12.

⁵⁰ T18-16:5-15.

⁵¹ T18-15:5-7

Dr Carey Breakey and Dr Trevor Sadler

- 2.47 Counsel Assisting relies heavily on the evidence of Dr Breakey and Dr Sadler as being supportive of the BAC model of care.⁵²
- 2.48 Dr Breakey's evidence should be treated with caution, for at least three reasons. Firstly, he was the founding director of the BAC. He was responsible for its creation. It is no criticism of Dr Breakey to state that he lacks objectivity when he is asked to give evidence about the merits of the facility he created.
- 2.49 Secondly, Dr Breakey is also semi-retired. He has not worked full-time in the mental health system for some years. This may explain why he displayed limited knowledge and experience of the continuum of adolescent mental health services currently in existence.⁵³
- 2.50 While Dr Breakey had undertaken some locum work at BAC in recent years, the amount of work he undertook was very limited (he worked at BAC for two days in 2008, one day in 2009, no days in 2010, eight days in 2011, 17 days in 2012, and 4 days in 2013).⁵⁴
- 2.51 Finally, Dr Breakey is not (and never has been) a fully qualified psychiatrist (he is not a member of the RANZCP). He lacks the expertise of some of the other witnesses.
- 2.52 Dr Sadler's evidence on the merits of BAC should also be treated with caution. Dr Sadler was the clinical director of BAC for 27 years (from 1989 to 2013). It is no exaggeration to say that the BAC was (until recently) Dr Sadler's life's work. It is no criticism of Dr Sadler to suggest that he may find it difficult to give objective and independent evidence about the merits of the BAC.
- 2.53 The evidence of clinical professionals who currently work full-time within the mental health system should be preferred to that of Dr Breakey and Dr Sadler.

Dr William Kingswell and other Queensland Health personnel

- 2.54 Counsel Assisting's submissions ignore the compelling evidence given by a number of clinical experts, that an extended inpatient unit was neither advisable nor necessary.
- 2.55 Dr Kingswell had first-hand experience of BAC over a number of years since 1994.⁵⁵
- 2.56 Dr Kingswell said that BAC was '*a violent and very, very difficult place*'.⁵⁶ He observed that the BAC was unique in Australia, and the 20 million Australians who reside outside of Queensland seem to function without a BAC. He said that to reinvent the BAC at Redlands '*would have been a terrible, terrible outcome*'.⁵⁷ Dr Kingswell says that the residential extended treatment units in New South Wales (such as the Walker Unit) had very different service models.⁵⁸
- 2.57 Drs Geppert, Cleary and O'Connell all testified that they understood that the BAC model was not contemporary, and explained why this was so.⁵⁹
- 2.58 Other witnesses who give evidence that institutional the model of care embodied in the BAC is not appropriate, and that the decision to close the BAC and develop new statewide services was correct include Ms Krause,⁶⁰ Mr Steer,⁶¹ and Mr McGrath.⁶²

⁵² Submissions of Counsel Assisting, paragraphs 16 to 25.

⁵³ T6-40 to T6-41.

⁵⁴ T6-43.

⁵⁵ T13-66:17-19.

⁵⁶ T13-19:10-29.

⁵⁷ T13-13:45 to T13-14:7

⁵⁸ T13-65:33-42.

⁵⁹ T10-12:1-18; T12-96 to T12-97:13-14.

- 2.59 **Fourth**, even if (contrary to fact) the terms of reference required the consideration of whether a BAC-like facility should exist in Queensland, the question posed by Counsel Assisting ("*is there a need for such a facility*") is the wrong question.
- 2.60 The question posed by Counsel Assisting assumes that the State has unlimited resources, so one only has to identify a need and it can and should be addressed. But the State of Queensland has limited resources, and there are many competing demands for them. As acknowledged by Mr Springborg, one of the government's roles is to allocate the State's limited resources among taxpayers' competing priorities.⁶³
- 2.61 Thus, the issue for decision-makers in the real world is not a simple question of whether a service or facility is "needed", but whether (recognising the many competing demands for funds) allocating funds to that service or facility *fairly represents the best use of limited public funds*.
- 2.62 Specifically with respect to a BAC-like facility (viz. a design-specific extended treatment and rehabilitation inpatient facility for adolescents presenting with complex and/or severe mental health issues), the question for decision-makers within the Health Department, WMHHS and CHQHHS, when designing a Statewide adolescent extended treatment and rehabilitation service, is what is the best way to deploy limited State funds. With the funds available, what is the best combination of services to support the target cohort? No doubt there are numerous services that are clinically desirable and, in one sense, needed, but which are not funded because there are other services which offer a greater return on the investment of the limited funds. The RANZCP submission to the Commission underlined this point very clearly.⁶⁴
- 2.63 These constraints are very real. Public resources are limited. The evidence is that the current government has *not* approved funding the full suite of AETR services proposed by CHQHHS (estimated in 2015 to cost \$22million per annum).⁶⁵
- 2.64 Thus, before it could be responsibly advocated that a BAC-type service is "needed", it would be necessary to:
- (a) identify the cost of providing that service (both capital and recurrent funding);
 - (b) identify what other services, currently provided or to be provided, could no longer be provided as funds are diverted to the BAC-type service; and
 - (c) justify why it was a better use of the funds to provide the BAC-type service rather than those other services.
- 2.65 To put it in concrete terms, assuming the funds were sourced from the AETR budget, what aspects of the current suite of services would be sacrificed for the BAC-type service? How many patients do those services support? What is the consequence of ceasing that support? None of these questions are even asked, let alone addressed, in the 200 pages of submissions of Counsel Assisting.
- 2.66 Counsel Assisting have made no attempt to undertake the analysis in the two previous paragraphs. As a result, their conclusion that a BAC-type service is "needed" is not only contrary to the weight expert evidence but is also, with respect, unhelpful. It provides no insight into the more pertinent question, which is: should Queensland have such a facility?

⁶⁰ Statement of Ms Krause (EXH.00072), paragraph 13, 48.

⁶¹ Statement of Mr Steer (EXH.00125), paragraph 27.

⁶² Statement of Pdraig McGrath (EXH.00087), paragraph 9.4 to 9.12.

⁶³ T15-5:9-15.

⁶⁴ RANZCP Submission (EXH.00144), 3 December 2015.

⁶⁵ See paragraph 8.14 below.

- 2.67 The evidence before the Commission is not of a quality to permit the required cost-benefit analysis to be done. What evidence there is suggests a BAC-type facility is expensive to build and very expensive to operate.⁶⁶
- 2.68 Further, the size of the population that might benefit from such a facility is very small:
- (a) the RANZCP's position was that the cohort which might benefit from an extended inpatient unit was 'extremely small';⁶⁷
 - (b) Professor McDermott said that in Queensland, the potential cohort might be in the order of "3 to 5 [beds] so a small number of individuals";⁶⁸
 - (c) Professor McGorry said that with community care elements in place, the number of patients who might benefit from an extended inpatient unit shrank considerably;⁶⁹ and
 - (d) Dr Stathis said that there had only been two referrals to subacute extended inpatient beds since the closure of BAC in January 2014.
- 2.69 These matters tend to tell against an investment in a new extended inpatient facility; or at least indicate that careful consideration be given to a decision to proceed with such an investment. That is particularly so given the well-known and potentially serious risks to children and adolescents from extended inpatient admission to a psychiatric facility.⁷⁰
- 2.70 **Fifth**, as to the second "real" issue (as to the sub-acute beds at LCCH), the submissions of Counsel Assisting fail either to acknowledge or to give adequate weight to two factors.
- 2.71 First, the submissions fail to acknowledge that LCCH beds are part of continuum of services developed by CHQ, which services include AMYOS and residential services. These other services provide services for many of the patients for whom only the BAC was an option.
- 2.72 Secondly and relatedly, as discussed above, the subset of patients for whom extended in-patient care is required is very small (see paragraph 2.68 above).
- 2.73 This evidence regarding the very small size of patients requiring extended in-patient subacute beds is consistent with Dr Stathis' evidence that there has only been two referrals to subacute extended inpatient beds since the closure of BAC in January 2014.
- 2.74 In the circumstances, there is no proper basis to speculate (as Counsel Assisting do at paragraph 114 of their submissions) that the low referral rate is due to a reluctance of clinicians to refer patients (a statement supported by no evidence at all), rather than an indication of the low demand given the range of other intensive services now available.

Conclusions

- 2.75 The foundational premise of Counsel Assisting's submissions – that a BAC-like facility is "needed" – is both (at a factual level) an incorrect assessment of the evidence and (at an analytical level) an incorrect and irrelevant premise upon which to base the inquiry called for by the terms of reference. It in turn undermines Counsel Assisting's analysis of the third "real" issue (the

⁶⁶ The estimated capital cost for Redlands was in the order of \$16 million to \$18 million: see paragraph X below. The recurrent costs for the BAC were some \$3.9 million: Briefing note of September 2014, paragraph 7 (LJS.900.001.0001 at .0066 – EXH.00120).

⁶⁷ T25-21:10-15.

⁶⁸ T7-44:40-50.

⁶⁹ T18-4:14.

⁷⁰ These are discussed in paragraph 8.24.

decision-making process), because that analysis is predicated on (and thus distorted by) a prior view that the decision-making must have arrived at the “wrong” result.

- 2.76 Given these fundamental flaws in Counsel Assisting’s submissions, the Commission should place little weight on those submissions.

3 Context: the legislative framework

- 3.1 The statutory framework for the delivery of health services in Queensland is discussed in **Appendix B** to these submissions, to which the Commissioner is respectfully referred.

4 Chronology of relevant events

- 4.1 Sections 5, 6, 7 and 8 of these submissions that follow, seek to address the matters relevant to the TOR in a chronological manner. It is appropriate, however, at the outset, to provide an overview of some of the key events. A more detailed chronology can be found in **Appendix A** to these submissions.

Prior to the March 2012 State election

- 4.2 In 2008, the QPMH was adopted by the Queensland Government.
- 4.3 At about the same time, a decision was made build a new extended adolescent in-patient facility, which when completed would replace the BAC.⁷¹
- 4.4 The replacement of BAC probably formed one part of the QPMH. Another part of the plan called for a redevelopment of The Park with a focus upon secure and forensic adult patients. This redevelopment was incompatible with the BAC remaining at The Park.⁷²
- 4.5 Redlands was selected as the site of the new facility to replace the BAC. The new facility at Redlands was originally scheduled to be opened by 2011. This was consistent with the time-frame for the separate redevelopment of The Park.⁷³
- 4.6 The Redlands project was, however, beset with delays. By early 2012, the model of service had still not been finalised; planning approval for the site had not been obtained; there were no finalised designs or drawings, and the project had not gone to tender.⁷⁴
- 4.7 The estimated costs of the Redlands project was also consistently over-budget. Having been up to \$4.8m over budget, as at February 2012 the costs were still some \$1.488m over budget.⁷⁵
- 4.8 At a more general level, the capital works program for stage 1 of the QPMH (of which the Redlands project formed a part) was also exceeding its budget. In 2011 it was necessary to increase the budget from the original budget of \$121m (plus GST) to \$148m (plus GST). There was recognition by September 2011 that Governor-in-Council approval was needed for this increased expenditure. However, by the time of the change of government in late March 2012, no Governor in Council approval had been sought or obtained.

⁷¹ See paragraphs 5.3 to 5.9.

⁷² See paragraphs 5.10.

⁷³ See paragraphs 5.40.

⁷⁴ See paragraphs 5.28 to 5.39.

⁷⁵ See paragraphs 5.41 to 5.46.

- 4.9 At this time, the Health Department was also consistently spending in excess of its budget. Dr O'Connell said that '*there had been a worsening overspend in the previous 5 years.*'⁷⁶ This required the Treasury to "bail out" the Health Department at the end of each financial year.⁷⁷
- 4.10 While the Redlands project was delayed, other parts of the QPMH continued to be progressed. In particular, the redevelopment of The Park continued. This included the move towards establishing something called the "EFTRU". As Redlands stagnated and the opening of EFTRU became closer, an inevitable problem began to loom: there were serious concerns about co-locating the BAC adolescents with the EFTRU patients, but the proposed new Redlands facility remained an indeterminate period of time away. Despite the mismatch in the timing of EFTRU and Redlands having being apparent from at least 2010 (that is, now in hindsight), there was apparently no identification of that risk, or proposal to mitigate it, by the then government or the architects of the QPMH.
- 4.11 During about late 2011 or early 2012, there commenced an extended discussion between the Chief Health Officer, Dr Young and the Mental Health Alcohol and Other Drugs Branch (**MHAODB**) about whether the "institutional" model of care represented by the Redlands project was still regarded as appropriate, or whether it would be better to adopt models of service that placed greater emphasis on decentralised and community-based care. This discussion is said to have occurred over several months prior to May 2012.⁷⁸ The start of this consultation, as with the other events above, pre-dated the appointment of Mr Springborg as Minister.⁷⁹

After the March 2012 State election

- 4.12 Mr Springborg became Minister for Health on 3 April 2012.⁸⁰
- 4.13 In about 3 May 2012, the Chief Health Officer issued a Briefing Note to the Director-General seeking his approval to cease the Redlands project. The note summarised the reasons for cessation as the delays to the project, its budget overrun and a proposed "re-scoping of the clinical service model and governance structure". The note foreshadowed that cessation of the Redlands project would require a review in the BAC model of care.⁸¹
- 4.14 On 16 May 2012, the Director-General gave the approval sought.
- 4.15 In July 2012 a CBRC submission proposed the "deferral" of the Redlands project, citing in essence the same reasons as those set out in the May 2012 briefing note.
- 4.16 On 28 August 2012 the Minister approved the reallocation of the funds previously allocated to the Redlands project, as well as other funds, to the urgent infrastructure maintenance needs of 12 regional hospitals. This was a response to a recently-discovered 2010 report that had identified those urgent needs.⁸²
- 4.17 In late 2012, WMHHS, the HHS responsible for providing the Statewide adolescent extended treatment and rehabilitation service then being provided by the BAC, instituted a project to consider the new model under which these services were to be provided. The project included creating the Planning Group and the ECRG. The Minister was briefed on the project on 12 December 2012.⁸³

⁷⁶ T12-16:20.

⁷⁷ T12-16: 15-21.

⁷⁸ Dr Young's statement at 21, 29, 31 and 32 (EXH.00186).

⁷⁹ See paragraphs 5.68 to 5.71.

⁸⁰ Statement of Springborg (EXH.00120), paragraph 1.

⁸¹ See paragraphs 5.56 to 5.60.

⁸² See paragraphs 5.61 to 5.63.

⁸³ See paragraphs 5.116 to 5.120.

- 4.18 In May 2013 the ECRG provided its report to the Planning Group. The Planning Group considered the report and other matters, and provided their recommendations to the Chief Executive of the WMHHS (Ms Dwyer).⁸⁴
- 4.19 The Planning Group's recommendations were considered by the West Moreton Board at its 24 May 2013 meeting. At that meeting, the Board resolved to support the closure of the BAC (subject to appropriate replacement services being provided).⁸⁵
- 4.20 The Minister was briefed by WMHHS on 15 July 2013. He was supportive of the Board's decision.⁸⁶
- 4.21 On 6 August 2013, WMHHS and CHQHHS issued a media statement about the proposed changes. On 6 and 7 August 2013 the Minister gave radio interviews in which he confirmed that as part of the changes to adolescent mental health services in Queensland, the BAC would be closing.⁸⁷
- 4.22 The last patient was transitioned out of the BAC on 24 January 2014, and the BAC closed on 30 January 2014.⁸⁸

After the January 2015 State election⁸⁹

- 4.23 Prior to the 2015 State election, the (then) Opposition made an election commitment to rebuild the BAC.
- 4.24 Since the 2015 State election, work has been undertaken in furtherance of that election commitment. This has included the establishment of a Youth Mental Health Commitments Committee, which has been tasked with responsibility for planning the establishment of the replacement BAC facility.
- 4.25 There appears to be a level of disquiet within CHQHHS about the proposal to rebuild the BAC. This is revealed in email exchanges before the Commission described in paragraphs 8.18 to 8.20. The sentiments expressed by CHQHHS clinicians are supported by a discussion paper prepared by CHQHHS in January 2016, which recommends investment into community care options and underlines a lack of evidence for, and risks of, treating adolescents in an extended inpatient facility.
- 4.26 Also, the government has declined to fund the \$22 million annual cost of the continuum of care developed by CHQHHS. The evidence does not reveal why this decision was made. Also, in July 2015 the government declined to fund the existing sub-acute inpatient beds at the Lady Cilento Children's Hospital.

5 The closure decision (TOR 3(a))

- 5.1 The evidence before the Commission points to three decisions, being:
- (a) *First*, a decision to close BAC made in about 2008, and to replace BAC with a new facility to be built at Redlands. The evidence shows that this decision was made against a backdrop of several reports critical of BAC, including a recommendation that BAC was in need of urgent replacement.

⁸⁴ See paragraphs 5.126 to 5.137.

⁸⁵ See paragraphs 5.138 to 5.145.

⁸⁶ See paragraphs 5.147 to 5.156.

⁸⁷ See paragraphs 5.168.

⁸⁸ See paragraphs 7.1.

⁸⁹ See paragraphs 8.15 to 8.23.

- (b) *Second*, a decision in early 2012 not to proceed with the building of the Redlands facility. The evidence shows that this decision was made in the context of advice that institutional-type models such as that at BAC and the proposed Redlands facility (viz. a stand-alone and design-specific Statewide extended rehabilitation inpatient facility) was outdated and inappropriate.

From late 2012 onwards, work was undertaken by expert groups to consider appropriate service model elements (ECRG and Planning Group) for adolescents with severe and persistent mental health problems.

- (c) *Third*, a decision in about May to August 2013 was made to proceed with the closure of BAC, and to develop and implement a new, Statewide model for of care for adolescents with severe and persistent mental health problems. This was done against the background of the cancellation of the Redlands project.

The new Statewide model (developed by a team from CHQ, but with particular input from Dr Stathis, Ms Krause and Ms Adamson) provided for a quite different approach to treating severely troubled adolescents than was hitherto in place in Queensland. The new model involved a "continuum of care". That continuum involved a strong focus on treating young people close to home, and in the community insofar as possible, and upon minimising inpatient treatment. The service delivery in the new "continuum of care" is contemporary, and seeks to avoid extended inpatient admission, having regard to (a) the lack of evidence supporting extended inpatient treatment for adolescents, and (b) the recognised risks from treating young people by extended inpatient stays.

As is discussed further in Part 8 below, since early 2015, CHQ has been working on a detailed discussion paper considering the evidence base for extended inpatient treatment and rehabilitation for adolescents with complex or severe psychiatric impairments. The discussion paper was completed in January 2016, and was the subject of oral evidence. Significantly, the discussion paper does not endorse the taking any steps to construct a new facility of the kind contemplated for Redlands. The recommendation of the paper is instead for available resources to be invested in further community-based services for Queensland adolescents.

The submissions will address each of these three decisions in turn, by reviewing the evidence in respect of each.

'First decision' – about 2008 to close BAC and replace with facility in Redlands

- 5.2 Dr Sadler's evidence is that a decision was made to close BAC as early as 1997, however the decision was reversed later that year.⁹⁰ The closure of BAC was raised again in the 2002 *Draft Report on the Need for Child and Adolescent Secure Services Inpatient Services and the Redevelopment of Extended Treatment Adolescent Inpatient Services*, however it was not actioned.⁹¹
- 5.3 A decision was made to close BAC and rebuild it elsewhere, in about 2008.⁹² The Australian Council on Health Care Standards had determined that the BAC was in need of urgent replacement.⁹³
- 5.4 A number of witnesses give evidence of their recollection that the original decision was made in about 2008, however few can be specific about who made the decision, when precisely it was

⁹⁰ Statement of Dr Sadler (EXH.00254), paragraph 218 to 219.

⁹¹ Statement of Dr Sadler (EXH.00254), paragraph 220.

⁹² Statement of Dr Corbett (EXH.00041), paragraph 14.1.

⁹³ Statement of T O'Connell (EXH.00094), paragraph 7(a).

made, and why. Dr Beakey gives evidence of correspondence from the government of the day about the decision to relocate BAC, which stated that considerable consultation with stakeholders had been conducted.⁹⁴

5.5 Ms Lane (who was Ms Dwyer's predecessor as Chief Executive of the WMHHS) gives the most complete evidence these matters.⁹⁵ Among other things, she says:

- (a) At some time prior to 2006, a review of all the services of The Park was commenced by the Department. The outcome of the review is contained in the Queensland Health Child and Youth Mental Health Plan 2006 - 2011 (**CYMHP**).⁹⁶ The CYMHP made a number of conclusions about the redevelopment of BAC, including that it should include an inpatient program for 18 occupied inpatient bed and eight day patients;
- (b) in 2008, a 'Site evaluation subgroup' was formed to consider the location of the redevelopment of BAC;
- (c) a Site Options Paper for the Redevelopment of the BAC identified that land adjacent to Redlands Hospital and that adjacent to The Park were the only viable options if the service was to be redeveloped as was currently envisaged; and
- (d) in April 2009, she received correspondence requesting WMHHS' approval of a plan to proceed with the redevelopment of BAC at Redlands.⁹⁷ The approval was granted.

5.6 Several reviews into BAC had been conducted around the time of this decision, including:

- (a) the Consultation on Aggression and Violence at the BAC, August 2003;⁹⁸
- (b) the Options Study for BAC, December 2004⁹⁹; and
- (c) the Review of Barrett Adolescent Centre, 2009.¹⁰⁰

5.7 The last-mentioned report made a number of adverse findings about the BAC facility as well as its model of care, including that:

- (a) *'it was evident that clinical practice at the unit was established on principles that had been developed some time ago. Apart from the external reviews of the unit, there was little evidence that BAC had recently reviewed and audited its clinical model against current accepted best practice and evidence based care.'*¹⁰¹ and
- (b) *'one of the major problems [with the clinical model] is the apparent lack of evidence-based treatments employed by the unit.'*¹⁰²

5.8 Ms Lane herself identified a number of problems with BAC, including inadequate patient safety, lack of privacy for patients, fixed gender ratios, and inadequate dining and recreational facilities.¹⁰³

⁹⁴ Statement of Dr Breakey (EXH.00172), Appendix D; WIT.900.002.0015.

⁹⁵ Statement of Pam Lane (EXH.00075)

⁹⁶ Statement of Pam Lane (EXH.00075), exhibit PL-14.

⁹⁷ Statement of P Lane (EXH.00075), paragraph 3.42 and exhibit PL-20.

⁹⁸ Statement of Dr Kingswell (EXH.00068), Annexure 5.

⁹⁹ Statement of Dr Kingswell (EXH.00068), Annexure 6.

¹⁰⁰ Statement of P Lane (EXH.00075), exhibit PL-35.

¹⁰¹ Statement of P Lane (EXH.00075), exhibit PL-35, page 6.

¹⁰² Statement of P Lane (EXH.00075), exhibit PL-35, page 7.

¹⁰³ Statement of Ms Lane (EXH.00075), paragraph 3.24.

- 5.9 While BAC was to be closed, it was intended to replace it with a new facility at Redlands. Notwithstanding that, as noted above, there had been some adverse comments about the model of care employed at BAC, the decision to replace the BAC with a new facility at Redlands was primarily driven by concerns about the inappropriate location of the BAC and the poor condition and design of the physical building. It seems that as at 2008 the prevalent view was the shortcomings of the BAC model of care could be addressed in the new model to be developed for the Redlands facility.¹⁰⁴
- 5.10 Dr Geppert¹⁰⁵ says that the closure and relocation was part of the Queensland Plan for Mental Health 2007-17 (**QPMH**).¹⁰⁶ However, the QPMH does not specifically mention BAC or adolescent mental health.
- 5.11 Dr O'Connell (who was the Director-General of the Health Department from 2011 to 2013) says that planning for the Redlands facility been underway since about 2008, and the main responsibility for planning the facility was delegated to the head of Mental Health (regarding clinical aspects and models of care) and to the Deputy Director-General responsible for Infrastructure (for non-clinical aspects of the infrastructure development).¹⁰⁷
- 5.12 Dr O'Connell is not able to be specific about whether the funding for the replacement of BAC was provided for in the QPMH, and says that he expects funding for the replacement would have been reconsidered each year as part of the State Budget process.¹⁰⁸
- 5.13 In contrast, Dr Geppert says that the QPMH did provide funding for the construction of the Redlands facility.¹⁰⁹ Dr Sadler also says that funding was allocated in the 2007 budget to rebuild BAC.¹¹⁰ The 2012 'Barrett Adolescent Strategy Project Plan' (discussed below) also states that a capital allocation had been approved to rebuild BAC in a new location.¹¹¹
- 5.14 Dr Geppert gave evidence that the Department's intention was to review and revise the Barrett model for the proposed Redlands facility; the Redlands facility was intended to adopt a new model of care. There was never an intention to '*pick up Barrett...and move it to another site.*'¹¹²

It is submitted that the Commission should make the following findings:

1. A decision was made in about 2008 that the BAC would close.
2. At that time, it was intended to build a new facility adjacent to the Redlands Hospital, which would continue to provide extended treatment and rehabilitation inpatient services for adolescents throughout Queensland.

¹⁰⁴ T13-13:45 to T13-14:7 (Kingswell); T10-8:30-38 (Geppert); Statement of McDermott, paragraphs 75 to 76 and 81 to 82; Statement of Groves (EXH.00058), paragraph 97.

¹⁰⁵ Statement of Dr Geppert (EXH.00055), paragraph 7.1.

¹⁰⁶ Located at https://www.health.qld.gov.au/publications/clinical-practice/guidelines-procedures/clinical-staff/mental-health/reports/08132_qpfmh07.pdf

¹⁰⁷ Statement of T O'Connell (EXH.00094), paragraph 4.

¹⁰⁸ Statement of T O'Connell (EXH.00094), paragraph 5.

¹⁰⁹ Statement of Dr Geppert (EXH.00055), paragraph 7.1.

¹¹⁰ Statement of Dr Sadler (EXH.00254), paragraph 222.

¹¹¹ Statement of S Kelly (EXH.00066), SK-10; WMS.0012.0001.14639 (EXH.00066) (WMHHS Project Plan).

¹¹² T10-8:30-40.

'Second decision' - 2012 decision within Queensland Health not to proceed with the Redlands project

- 5.15 In 2012, a decision was made that the Redlands project would not proceed. This decision was made for a number of reasons:
- (a) most importantly, there were developments in clinical thinking which meant that the institutional model represented by BAC and the Redlands facility was no longer considered best practice. This is explained in more detail in paragraphs 5.16 to 5.27 below; and
 - (b) there were also practical issues with progressing the physical build. They included environmental issues, budget overruns, and delays in finalising its model of care. This is explained in more detail from paragraph 5.28 below.

Changes in clinical practice and thinking since 2008

- 5.16 At the time the QPMH was adopted in 2008, an institutional model for adolescent extended treatment and rehabilitation was, it seems, regarded as appropriate.
- 5.17 The QPMH was a ten year plan, intended to span 2007 to 2017.
- 5.18 This meant that, inevitably, over the ten year course of its implementation, the QPMH would need to be revisited to take into account developments in clinical thinking and other changes in circumstances. In the case of the QPMH, these other changes included the shift to independent, de-centralised HHSes as part of the National Health Reform Agreement with the Commonwealth,¹¹³ and the changing fiscal environment.¹¹⁴
- 5.19 The evidence is that clinical thinking further developed after the adoption of the QPMH in 2008. A (long term) trend away from extended stay inpatient units for mentally ill young persons, and away from "institutional" interventions generally, in favour of intensive treatment in the community and "close to home" (viz. with inpatient units being reserved for stabilising the patient prior to discharge into a community setting, and with further rehabilitation and treatment being undertaken in a community-based step up/ step down service such as Y-PARC, or other service), led to a reconsideration of the appropriateness of the Redlands project from a clinical perspective. Dr O'Connell gave evidence that the Commission should accept about the need for a ten year plan to be flexible and to adapt to changes in circumstances, including changes in clinical thinking.¹¹⁵
- 5.20 The appropriateness of the Redlands concept was considered over several months by the MHAODB and the Chief Health Officer in the period leading up to the eventual decision in May 2012 to cease the Redlands project.¹¹⁶
- 5.21 This re-consideration of Redlands came in the context of a wider process of consideration of the BAC model, and youth mental health policy in general. This occurred in the context of developments in the National Mental Health Framework (which, the evidence was, had to be understood and followed if Commonwealth funding was to be provided for new services).¹¹⁷ In particular:

¹¹³ T13-18:42 to T13-19:6 (Dr Kingswell).

¹¹⁴ T12-20:18-22 (Dr O'Connell); T10-8:15-40 (Dr Geppert); T13-18:35-45 (Dr Kingswell)

¹¹⁵ T12-39:1-30.

¹¹⁶ Statement of Dr Young (EXH.00186), paragraph 29; T21-96:7-12; T21-98:5-21.

¹¹⁷ T13-18 to T13-19 (Kingswell).

- (a) The 2003 review in the BAC by Professor McDermott and Dr Powell raised concerns about the model of service and the manner in which the service linked into other CYMHS services.¹¹⁸

- (b) The National Mental Health Policy 2008, which stated (p17, emphasis added):¹¹⁹

*'Beyond primary care, consideration must be given to the best way to configure the specialist mental health sector to guarantee that it is responsive to the needs of people with mental illness. ... **At the area/regional level, the full range of mental health services should be provided by integrated programs, ensuring a balanced and responsive mix of community and inpatient services. The important role played by private providers of inpatient and community mental health services is recognised. Community treatment should be the treatment of choice wherever appropriate, but inpatient care must be available when required.** Core community services should include, but not be limited to, crisis assessment and emergency intervention, acute treatment and continuing care, as well as community-based residential support. Core inpatient services should include both acute and non-acute components. **Non-acute bed-based services should be community based wherever possible and promote maximum independence and autonomy consistent with safety and physical well-being.***

- (c) The Fourth National Mental Health Plan, which was to cover the period 2009 to 2014.¹²⁰

- (d) The 2009 Walter review into the BAC, which again raised concerns about the model of service and the manner in which the service linked into other CYMHS services.¹²¹

- (e) The work by MHAODB in 2010 and 2011 to develop a child and youth mental health strategy,¹²² which strategy was to:¹²³

'build on the Queensland Government's 1996 Policy Statement Future Directions for Child and Youth Mental Health Services. The policy will be guided by more recent State, National and international policies and papers that target mental health issues and associated issues for young people. These include but are not limited to the QPMH, the Fourth National Mental Health Plan, the National Mental Health Policy 2008, and the Headspace integrated health service centre model of the National Youth Mental Health Foundation.'

- (f) The draft National Mental Health Framework, which Dr Kingswell testified did not support a facility like the BAC or Redlands (a point that was later reflected in the Planning Group's response to the ECRG Report).¹²⁴

5.22 The Commissioner should find that this on-going local and national dialogue among clinicians and policy-makers, informed the thinking, in 2012, of the MHAODB and the Director-General in relation to Redlands.

¹¹⁸ Statement of Dr Groves (EXH.00058), paragraphs 85 and 88.

¹¹⁹ COI.015.0002.0001.

¹²⁰ Statement of Dr Groves (EXH.00058), paragraph 44(g), exhibit AG-6; GRA.010.001.0889 (GRA.020.001.0198).

¹²¹ Statement of Dr Groves (EXH.00058), paragraphs 86 and 88.

¹²² T21-68:6-11.

¹²³ QHD.007.001.3528 (EXH.00219).

¹²⁴ T13-19:15-25; see also planning group recommendations, paragraph 2(a) *'Models involving a statewide clinical bed-based service...are not considered contemporary within the National Mental Health Service Planning Framework.'*

- 5.23 Dr O'Connell, the Director-General at the time, testified that the emerging clinical views in relation to the appropriateness of mental health care in an institutionalised setting were reached over a number of years.¹²⁵
- 5.24 Dr Young recalls '*significant discussion and debate about whether it was better to have a single service in a single location...with the associated dislocation of adolescents from the families or whether it was preferable to provide services throughout the State.*'¹²⁶
- 5.25 Through the discussions leading up to May 2012, the MHAODB, principally Dr Kingswell and, it seems Dr Gilhotra¹²⁷ (the Chief Psychiatrist), and Dr Geppert¹²⁸, formed the view that the single-facility, extended inpatient concept of service delivery that was reflected in the Redlands project, was not contemporary.
- 5.26 This advice was provided to, and accepted by, Dr Young.¹²⁹ It was Dr Young who requested and verified a briefing note in May 2012 seeking the Director-General's approval to cease the project.¹³⁰ As Chief Health Officer, one of Dr Young's responsibilities was to provide high-level advice to the Director-General on health issues, including policy and legislative matters associated with the health and safety of the Queensland public: section 53 *Hospital and Health Boards Act 2011 (HHB Act)*. Seeking the Director-General's approval for this important matter fell squarely within Dr Young's statutory function.
- 5.27 Dr O'Connell gives evidence as to his own decision-making process when approving the cancellation of the project on 16 May 2012. Dr O'Connell emphasised the seriousness and importance of the decision, as he saw it.¹³¹ Dr O'Connell testified:
- 'You say most importantly. Now, was that your professional opinion at – I withdraw that. Was that your opinion at the time in May 2012 that that was the most important actuating factor? I think one of the marks of my time as Director-General was that I concentrated on the interests of the patients. So, yes, I think it would have been a feeling that I had both at that time and currently. The other – the other reasons can be surmounted to some extent. You can always eventually wait for koala approval to occur or you can always wait until funds become available to bridge the gap between the current spend. But something like, you know, a changing opinion about what's best for the patients – you know, you have to take into account, and it becomes a very significant factor in the – putting it all together.'*¹³²

The Commissioner would accept this evidence.

Practical problems with the project – site issues, model of care issues, budget issues

- 5.28 The project encountered a number of significant problems. These can be divided into:
- (a) site issues;
 - (b) model of care issues; and
 - (c) budget issues.

¹²⁵ Supplementary Statement of Dr O'Connell (EXH.00094), paragraph 4(b); T12-28: 38-41.

¹²⁶ Statement of Dr Young (EXH.00186), paragraph 21.

¹²⁷ Statement of S Kelly (EXH.00066), paragraphs 9.2 to 9.5; T21-97:36-37; T21-98:15.

¹²⁸ T10-11 to T10-12.

¹²⁹ Statement of Dr Young (EXH.00186), paragraph 31; T21-82:27-29.

¹³⁰ Statement of Dr Young (EXH.00186), paragraph 16.

¹³¹ Statement of Dr O'Connell (EXH.00094), paragraph 10 and 11.

¹³² T12-45:35-44.

- 5.29 Each will be addressed in turn. Before doing so, the approach of Counsel Assisting to these matters will first be considered.
- 5.30 *Counsel Assisting* The causes, extent and effects of the delay to the Redlands project was not investigated or indeed even seriously considered by Counsel Assisting. The focus of the oral examinations was, instead, to seek to cast doubt on the existence or extent of the problems besetting the project: see for example the cross examination of Dr Kingswell.¹³³ Moreover, and more remarkably, Counsel Assisting did not present to the Commissioner any of the contemporaneous documents charting the significant problems that emerged with this infrastructure project, or call any evidence from the persons with the Health Infrastructure Branch who were best placed to give evidence about the nature and extent of those problems. The inference is that Counsel Assisting adopted this approach because it fitted with the particular narrative that Counsel Assisting wished to present to the Commissioner, and that is now reflected in the written submissions of Counsel Assisting.
- 5.31 Based upon the material made available to Mr Springborg by the Commission, and that has been the subject of evidence, the following appears to be reasonably clear.
- 5.32 *Koala habitat* Whilst it is correct that this issue was identified at the outset of the project, it is equally clear that the full extent of the problems that this would cause was never anticipated. In particular, in June 2009, and after the Redland site had been acquired in March 2009,¹³⁴ the Government adopted a new response to the "crisis in koala numbers" by imposing a freeze on the clearing of State-owned land in southeast Queensland.¹³⁵ The significance of the problems presented by the new koala-related environmental strategies is apparent from the fact that the issue was escalated to Mr Glaister, the Deputy Director-General, Health Planning and Infrastructure Division for Queensland Health. Mr Glaister recalls "*this issue was escalated to my office as the viability of the project became questionable as there were caveats over the land for the protection of koalas.*"¹³⁶ This was an unexpected development that created significant delay.¹³⁷ The issues arising rose even to the level of formal correspondence between the Hon Paul Lucas MP, the Deputy Premier, and the Hon Kate Jones MP: see the letter attached to a Briefing Note for the Redlands project dated 17 December 2009.¹³⁸
- 5.33 *Planning issues* The Redlands site was several hectares acquired at a cost of some \$10million. The site was always intended to accommodate new buildings for the Redlands hospital, as well as the replacement buildings for the BAC (which were anticipated being located at the rear of the site). Planning approval required a CID process to be completed (Community Infrastructure Design). A Briefing Note to the Director-General dated 24 January 2012 recorded that, among several different options, Health Infrastructure Branch had decided to proceed with an option whereby a CID process for the *whole* site would occur first, including approval for the new infrastructure intended for the Redlands hospital. This process would, naturally, be a time-consuming process.¹³⁹ There is no evidence that this process had even begun by the time the Redlands project was cancelled in May 2012.
- 5.34 *No approved model of service* Part of the delay was due to a delay in finalising the model of service. The model of service needed to be finalised to allow a building design to be finalised. The delay to the project caused by delay in finalising the model of service was recognised in draft letter to the Premier attached to a November 2011 Briefing Note to the Director-General:¹⁴⁰

¹³³ At T13-9:38: '*Forgive me Dr Kingswell, but that seems quite a relatively painless process.*'

¹³⁴ QHD.004.015.2811 (EXH.00226) at 2813 (paragraph 11(c)); QHD.004.014.8371 (EXH.00226) (paragraph 5).

¹³⁵ QHD.006.005.1554 (EXH.00237) at .1557; T13-73:15-40.

¹³⁶ Statement J Glaister, paragraph 10.

¹³⁷ T13-9:18-22 (Dr Kingswell).

¹³⁸ QHD.004.014.4244 (EXH.00239).

¹³⁹ QHD.004.014.8371 (EXH.00226).

¹⁴⁰ QHD.007.002.1462 (EXH.00265) at .1469; T12-10:5-32 (Dr O'Connell); T13-9:35-40 (Dr Kingswell); T21-85:30-46 (Dr Young).

'Other issues that have delayed the delivery of these projects include the extended time frame taken to develop appropriate models of care and the development of appropriate scopes of work prior to the standard architectural design processes commencing.'

- 5.35 Up to 20 June 2012, Dr Kingswell had responsibility for approving the draft model of service, once finalised, being prepared by Dr Crompton.¹⁴¹ However, as at mid 2012, *'there was still some consultation going on around [the draft model of service] and that, in fact, the final model of service had been an additional stumbling block to resolving the design and getting the building approvals going'*.¹⁴² (The Commission will recall that the evidence of other witnesses is that even today, there exists no model of service for an extended inpatient treatment and rehabilitation facility: and that this is in turn connected to the lack of evidence supporting the efficacy of this kind of therapeutic intervention.)
- 5.36 *Cumulative effect of problems* A Briefing Note to the Deputy Director-General, Health Planning and Infrastructure Division, summarised issues that beset the project, in June 2011:¹⁴³
- 'the Redland Adolescent Extended Treatment Unit project has encountered issues with extended land acquisition timeframes, delays in confirming the model of service delivery to inform the Project Definition / Schematic Design, the requirement to address environmental issues under the Koala Conservation State Planning Regulatory Provisions implemented after the land was acquired and the inability to progress the Community Infrastructure Designation process for the site until the facility design had progressed to a point where proposed building locations documented...'*
- 5.37 The delay was so acute that in late 2011 the Health Planning and Infrastructure Division commissioned Savills Project Management to advise on accelerating the project (and others).¹⁴⁴
- 5.38 Dr O'Connell gives evidence that as at 9 October 2011, the construction of the Redlands facility had not yet gone to tender, and as at May 2012, Council approval had not been sought, nor had the approval of the relevant Deputy Director-General been obtained for the commencement of the build.¹⁴⁵
- 5.39 The net result was, as Dr Kingswell said: *'... as at May 2012, no design, no building approvals, the process for community infrastructure designation hadn't even commenced. Four years had gone past. I'm struggling to understand which bit of that was painless.'*¹⁴⁶
- 5.40 The progressively-worsening delay to the project can be illustrated by the following table of the estimated completion date for the project. Notwithstanding the passage of time, the project was always estimated to be two years away from completion.

Date of estimate	Estimated completion of Redlands	Cumulative delay	Source
Feb 2010	Construction to start December 2010 Facility open August/October 2011		QHD.007.001.1928
Sep 2011	Construction expected to commence Oct 2012 Practical completion October 2013	24 months	QHD.006.005.2722

¹⁴¹ T13-9:27.

¹⁴² T13-9:35-40 (Dr Kingswell).

¹⁴³ QHD.004.015.2811 (EXH.00226) at 2813 (para 11(c)).

¹⁴⁴ QHD.007.002.1462 (EXH.00265) at 1464, paragraph 21. Even with Savills' input, the estimated completion date was only brought forward by 1 month, from November to October 2013.

¹⁴⁵ Statement of T O'Connell (EXH.00094), paragraph 7(b).

¹⁴⁶ T13-9:42-45.

Nov 2011	Completion expected November 2013	25 months	QHD.007.002.1442 (an attachment to QHD.007.002.1462)
Feb 2012	Construction expected to commence Jan 2013 Practical completion January 2014	27 months	QHD.004.014.8371
2012	Completion expected 'mid 2015'	45 months	QHD.004.015.7533

- 5.41 *Over-budget* As well as delayed, the Redlands project was consistently over-budget.
- 5.42 Briefing notes in May 2010¹⁴⁷ and late 2011¹⁴⁸ noted it was over budget by \$4.8m and \$2.8m respectively.
- 5.43 Dr O'Connell's evidence is that as at 29 June 2011, funding of \$16,126,432 was available for the Redlands project.¹⁴⁹ This was less than the estimated cost of the project, which was \$18,891,443.
- 5.44 In early 2012, the Steering Committee endorsed proceeding with the project – even though the then current cost estimate exceeded the budget by \$1.488m – '*in anticipation of a competitive tender*'.¹⁵⁰ The response to this proposal, from Dr Aaron Groves (then the Director of MHAODB) on 22 February 2012 was:¹⁵¹

'CDP can not go to tender when pre-tender estimate is above project budget (regardless of what Steering Committee decide).

3 options, reduce scope, clarify assumptions with QS to get more accurate pre-tender estimate or seek additional funds.'

- 5.45 *Project considered not viable* The on-going delays and other problems with the Redlands project led to the conclusion within at least MHAODB, that it was not a viable project. Dr Geppert, who was in a position to know the view of the MHAODB, was very clear about that.¹⁵² This evidence was not contradicted and should, it is submitted, be accepted.
- 5.46 Even strong advocates of the BAC model came recognise that the practical and cost problems with the Redlands project meant its viability was tenuous. For example, on 21 March 2012, Dr Sadler wrote to Dr Kingswell, noting:¹⁵³

"As you are aware, the Redlands site faces significant hurdles - an over run in estimated cost, gaining DERM approval for the site and weathering community concerns about building on koala land. My understanding is that any of these may become an insurmountable obstacle. Naturally no one discusses possible alternatives while there is hope. My concern is that we may come to a dead end and then begin the process of considering options."

Implications of delay in Redlands project on the Park redevelopment

- 5.47 As was noted earlier, while the Redlands project stalled, other parts of the QPMH continued to be progressed. The refocussing of the Park toward adult services, and adult forensic services in

¹⁴⁷ QHD.004.014.6973 (EXH.00241).

¹⁴⁸ QHD.006.005.2722 (EXH.00225).

¹⁴⁹ Statement of Dr O'Connell (EXH.00094), paragraph 8.

¹⁵⁰ QHD.004.014.8371 (EXH.00226), paragraph 8.

¹⁵¹ QHD.004.014.8371 (EXH.00226), manuscript annotations.

¹⁵² Statement of Dr Geppert (EXH.00055), paragraph 3.3 to 3.5.

¹⁵³ QHD.004.014.7257 at 7258.

particular, continued. This included establishing an Extended Forensic Treatment and Rehabilitation Unit (**EFTRU**). This new unit was to be used for adult forensic patients who were formerly detained in a secure facility. Part of their rehabilitation was to be by transition to a non-secure residential unit, the EFTRU, and, if appropriate, later into the community. This new unit had been in train since at least 2009.¹⁵⁴

- 5.48 The changes to The Park, and EFTRU in particular, were incompatible with the BAC remaining at The Park. This incompatibility had been recognised as early as 2008: the Site Options Paper for the Redevelopment of the Barrett Adolescent Centre dated October 2008, which led to the selection of the Redlands site for the development of the new adolescent service stated, in relation to the possibility of developing the new service at the existing BAC site:¹⁵⁵

'.. the close proximity of the site to the growing high security and extended treatment forensic programs compromise this option. Redeveloping the unit in close proximity to mentally ill offenders is likely to pose clinical and practical challenges and may become a matter of public interest.'

- 5.49 EFTRU was, according to the witnesses from West Moreton Hospital and Health Service (**WMHHS**) who were responsible for it, a new and in that sense untried service.¹⁵⁶

- 5.50 As Dr Kingswell stated, there became an 'urgency to close' the BAC, because the risk that EFTRU posed to adolescents admitted to BAC.¹⁵⁷ He explained:¹⁵⁸

'The EFTRU is...like a community care unit for mentally ill offenders. It's open. They can walk out. It has a gate. The likelihood of some harm coming to an adolescent on that site might not have been high...but the magnitude of the problem that you were going to visit if something went awry was going to be catastrophic, and had anything like that occurred I'd be sitting in front of an inquiry...answering a very different set of questions. People would be asking 'what were you thinking leaving a group of vulnerable children on that site with that population?'

- 5.51 Dr Kingswell has further explained in a statement to the Commission¹⁵⁹ at 1a:

'The 'looming problem' was that the Extended Forensic Treatment and Rehabilitation Unit (EFTRU) at The Park Centre for Mental Health (The Park), was to be opened and would be within the vicinity of the BAC. To my mind this represented a new risk that had not previously existed. While adult forensic patients had been at The Park for many years, they were in very secure facilities. EFTRU was proposed to be far less secure. While it was to house adult forensic patients who it was considered by those treating them as being ready to transition out of high security facilities, nonetheless they would be forensic patients who were either not yet ready to be out in the community or about whom there was some doubt about their readiness. Even through the chances of some adverse incident occurring might have been relatively low with supervision, to my mind the consequences of something adverse happening may well be catastrophic, meaning that it was a risk that should not be taken.'

- 5.52 Had the Redlands facility opened by 2011 (as was originally intended) the opening of the EFTRU would have posed no difficulty.

¹⁵⁴ Supplementary Statement of Ms Dwyer, exhibit LD-2.

¹⁵⁵ Supplementary Statement of Ms Dwyer, paragraph 1.8.

¹⁵⁶ T11-72: 10-20 (Ms Kelly).

¹⁵⁷ T13-19:30-45.

¹⁵⁸ T13-20:5-15.

¹⁵⁹ Supplementary Statement of Dr Kingswell

5.53 The mismatch in timing between the opening of the EFTRU and the Redlands project had becoming very clear by September 2011. A briefing note to the Director-General at that time¹⁶⁰ notes that:

- (a) EFTRU is *'on track for delivery by June 2012'*¹⁶¹ but
- (b) the Redlands project has *'encountered numerous issues causing delays'*, with *'[c]ompletion expected November 2013'*¹⁶²
- (c) the Health Planning and Infrastructure Division had commissioned Savills Project Management to advise on accelerating the delayed projects;¹⁶³ but
- (d) even with acceleration the Redlands project would not be complete, it was said, until October 2013.¹⁶⁴

5.54 As Dr Kingswell stated:¹⁶⁵

'It [Redlands] was unlikely to be built in any time soon and we had a looming problem with the Barrett Adolescent Centre on the site that it was on and we needed a solution to that. Redlands wasn't going to deliver that solution for us, not in a timely way.'

5.55 This was a structural problem inherited by Mr Springborg when he was sworn in as Minister in April 2012.

The decision to cease the Redlands project May 2012

5.56 *May 2012* A decision to cancel the Redlands project was made on 16 May 2012. It was made by the then-Director-General, Dr O'Connell.¹⁶⁶ He did so on the advice of Dr Young and the MHAODB, who were the signatories to the May 2012 briefing note.¹⁶⁷

5.57 The briefing note¹⁶⁸ is dated 3 May 2012, and is addressed to Dr O'Connell 'for approval'. Dr O'Connell signed the document, and indicated his approval to cancel the project, on 16 May 2012. The only conclusion is that Dr O'Connell approved the cessation of the Redlands facility on 16 May 2012.

5.58 The briefing note indicates that it was to be provided *'To Minister's Office for Approval'*. However there is no evidence that the Minister's office ever received the briefing note. Mr Springborg does not recall he or his office receiving the note.¹⁶⁹

5.59 *June 2012* In June 2012 a CBRC briefing note considered the Redlands project.¹⁷⁰ It seems the author of the note it did not appreciate that the Director-General had already approved cessation, for it referred to "deferring" the project. The note summarised the reasons for deferral as being:

¹⁶⁰ QHD.007.002.1462 (EXH.00265).

¹⁶¹ QHD.007.002.1442 (EXH.00266) (being Attachment 1 to the briefing note QHD.007.002.1462 (EXH.00265)) at .1443.

¹⁶² QHD.007.002.1442 (EXH.00266) (being Attachment 1 to the briefing note QHD.007.002.1462 (EXH.00265)) at .1444.

¹⁶³ QHD.007.002.1462 (EXH.00265) at .1464, paragraph 21.

¹⁶⁴ QHD.007.002.1462 (EXH.00265) at .1464, paragraph 22.

¹⁶⁵ T13-11:10-13.

¹⁶⁶ LJS.900.001.0032 (EXH.00120); T12-15:20-24.

¹⁶⁷ T12-29:37 to T12-30:15.

¹⁶⁸ Statement of Dr Kingswell (EXH.00068), Annexure 4; DBK.900.001.0083 (DBK.001.001.0032).

¹⁶⁹ T15-2:46 to T15-3:27.

¹⁷⁰ DPC.005.001.0001 (EXH.00252).

'due to the capital program having encountered multiple delays to-date, an estimated budget over-run of \$1.46 million (with a total capital project cost of \$17.59M), and recent sector advice that proposes a re-scoping of the clinical service model for the Unit.'

5.60 The evidence is that the Minister was, at about this time, aware of recent sector advice to which the note referred. That is because about this time, the Minister became aware that senior clinicians within the Department had expressed the view that a facility like the Barrett Centre was not the most appropriate model for caring for severely troubled adolescents, and that the preferred model involved the provision of services in the community, closer to the patient's home, and a move away from long-term institutional care.¹⁷¹ This evidence from Mr Springborg is not contradicted and should be accepted.

5.61 *August 2012* In August 2012 the Minister received a briefing note seeking approval of the allocation funds to be applied to urgent maintenance the 12 rural hospitals. The briefing note noted that one source of the funds was the cessation of Redlands. The Minister approved the proposal by signing the briefing note on 28 August 2012.¹⁷² By doing so, the Minister approved the allocation of funds; he was not approving the cessation of the projects which had made the funds available for application to the urgent needs of the 12 rural hospitals. As Dr O'Connell explained:¹⁷³

'[The August 2012 briefing note] isn't requesting the Minister to approve the cessation of the Redlands project. This is merely informing the Minister that that's one of the sources of funds to accumulate 41 million for these new projects.'

5.62 It was also the understanding of Mr Springborg¹⁷⁴ (today) and Dr Young¹⁷⁵ (who signed the August 2012 briefing note as Acting Director-General) that the decision to cease the Redlands project had already been made in May 2012.

5.63 The focus of the August 2012 briefing note was on the reallocation of funds from a project that had previously been cancelled. The focus was not upon whether the earlier decision to cancel that project was correct or should be revisited. A detailed analysis of the reasons for ceasing the Redlands project would therefore not be expected in the August briefing note. Even so, the attached briefing note to the Director-General made clear that Dr Kingswell (an experienced psychiatrist who had previously overseen The Park, and at that time the Executive Director of the Mental Health Branch) had recommended ceasing the Redlands project: at paragraph 14.

5.64 Of course, the cessation of Redlands did not end the services provided at BAC. It meant that the proposed replacement for the BAC at Redlands was being cancelled. That had the consequence that there would need to be further work done, later, to develop a new replacement services to meet the clinical needs hitherto met, or sought to be met, by the BAC. As the May 2012 briefing note to the Director-General stated (at paragraph 7):

'Ceasing the 15-bed RAETU capital program will necessitate a review of the existing adolescent centre at The Park, and should give consideration to the benefits and disadvantages of this model of care.'

5.65 As will be seen, that is indeed what occurred next.

¹⁷¹ Statement of Mr Springborg (EXH.00120), paragraph 40.

¹⁷² Supplementary Statement of L Springborg (EXH.00214), paragraph 8; LJS.900.001.0036.

¹⁷³ T12-45:12-15.

¹⁷⁴ T15-4:17-26; T15-16:43 to T15-17:3; T15-22:14-19.

¹⁷⁵ T21-73:19-37.

Reasons for the cancellation of the Redlands project

- 5.66 The evidence indicates that the Redlands project was cancelled for a number of reasons.
- 5.67 Dr O'Connell gives the clearest evidence about the decision not to proceed with the Redlands project. It is submitted that, as Director-General at the time and the person who authorised the cessation of the project, he is in the best position to give relevant and reliable evidence on this topic. Dr O'Connell says that the decision was made over a period of time as a result of consultations between various stakeholders, and identifies a number of reasons for the decision, including:¹⁷⁶
- (a) delays in confirming the model of service delivery;
 - (b) sensitivity to health facilities being flood-prone (the chosen site was low-lying);
 - (c) budgetary constraints;
 - (d) conservation issues; and
 - (e) '*most importantly*, an emerging clinical preference to care for patients currently treated in the BAC in more community-based closer-to-home models of care, rather than in an institutionalised model.
- 5.68 As noted earlier, the view appeared to have been reached that the project was not viable. The delays, practical problems and cost overruns contributed. But the evidence from the decision-makers, Dr O'Connell, Dr Young and Dr Kingswell, is that the most important factor was the emerging clinical preference to care for patients currently treated in the BAC in more community-based, closer-to-home models of care, rather than in an institutionalised model (viz extended inpatient admission). Dr O'Connell's evidence is clear that even if there had not been a Fiscal Repair Strategy and Commission of Audit, the Redlands project would not have been progressed.¹⁷⁷
- 5.69 With respect to the emerging clinical preference being the most important factor, Dr O'Connell explained:¹⁷⁸

'Was that your opinion at the time in May 2012 that that was the most important actuating factor? --- I think one of the marks of my time as Director-General was that I concentrated on the interests of the patients. So, yes, I think it would have been a feeling that I had both at that time and currently. The other – the other reasons can be surmounted to some extent. You can always eventually wait for koala approval to occur or you can always wait until funds become available to bridge the gap between the current spend. But something like, you know, a changing opinion about what's best for the patients – you know, you have to take into account, and it becomes a very significant factor in the – putting it all together.

When you say "my time as Director-General was", in your mind, characterised by the focus on patients, as I understand your evidence, the reason you say the most important factor in the cessation of Redlands was the emerging clinical preference. By that, am I understanding you to say that in your mind it was the interests of – I withdraw that – it was the best thing to do in the interests of the patients? --- Yes.

¹⁷⁶ Statement of T O'Connell (EXH.00094), paragraph 10(a).

¹⁷⁷ Statement of T O'Connell (EXH.00094), paragraph 10.

¹⁷⁸ T12-45:12-15.

Do you recall expressing that opinion to the Minister? --- I can't remember specifically saying that to him about this point, but he knew that that was my overall way of working as Director-General. We shared that opinion.'

5.70 Dr Young's evidence corroborates that of Dr O'Connell: Dr Young's statement at 21 and 31.

5.71 The Commissioner would note, finally, that:

- (a) Dr O'Connell's decision to cancel the Redlands project fell squarely within the statutory role mandated for the Director-General by section 8(3)(a)&(c) and 45(a), (b), (c), (d) and (h) of the *Hospital and Health Boards Act 2011* (Qld); and
- (b) Dr O'Connell's oral evidence made very clear that he regarded this decision as a very significant one, and one that he did not take lightly.¹⁷⁹

Funding issues – effect on Redlands

5.72 A number of witnesses acknowledge the 'tight fiscal environment'¹⁸⁰ in which the decision to cancel the Redlands project was made.

5.73 However, there is no evidence that funding issues caused the cessation of the project.

5.74 Indeed, the submissions of Counsel Assisting concede that there is no direct evidence that the Department's need to find savings altered the decision-making in relation to the Redlands project.¹⁸¹

5.75 Of course, public administration always involves a choice about how limited resources will be allocated between competing demands. A key role of an elected government is to make those choices, assisted by appropriate expertise from within the relevant Department.

5.76 Insofar as the Commissioner considers funding issues to be relevant to the matters to be considered, it is submitted that the following matters are established by the evidence:

- (a) Prior to the 2012 election, Queensland Health had an underlying deficit (viz. actual expenditure exceeded the budgeted expenditure for the year) which had been worsening, with an over-spend approaching \$300 million in 2010-11.¹⁸²
- (b) As Dr O'Connell explained in his oral evidence, the true position was not apparent, because Queensland Health would simply seek more funds from Treasury: '*the [health] system had overspent what Treasury had allocated. It doesn't appear that way in the annual statements because Treasury had effectively bailed out the Department of Health towards the end of the financial year. But there had been a worsening overspend in the previous five years.*'¹⁸³
- (c) In addition, Stage 1 of the QPMH (which included the Redlands project) was never fully funded. No funding had been provided for the recurrent expenses of operating the additional 140 beds to be created.¹⁸⁴ At some point, that lack of funding needed to be addressed.

¹⁷⁹ T12-45:35-44.

¹⁸⁰ Statement of T O'Connell (EXH.00094), paragraph 10(b).

¹⁸¹ Submissions of Counsel Assisting, paragraph 195.

¹⁸² Statement of T O'Connell (EXH.00094), paragraph 10(e).

¹⁸³ T12-16:18-22 (Dr O'Connell).

¹⁸⁴ T12-19:35-42.

- (d) Compelling and uncontradicted evidence of the lack of funds to fully implement the QPMH is contained in Estimates Brief 25.7 (dated July 2011), which states that '*No funding in the 2011-12 State budget to progress implementation of the Plan due to fiscal pressure.*'¹⁸⁵
- (e) By, at the latest, September 2011, it was appreciated that Governor-in-Council approval would be needed to increase the expenditure on the Stage 1 Capital Works program from \$121,209,000 (GST exclusive) (viz. as originally approved by the Governor in Council in December 2007) to \$148,351,000 million (GST exclusive) (the revised expected cost).¹⁸⁶ There is no evidence that the Governor-in-Council approval for the \$27 million increase in the funds needed, was either sought or obtained. The Commission should conclude that this approval was not sought or obtained.¹⁸⁷

5.77 Following the change in government in early 2012, the position was that:

- (a) the Health Department expenditure was expected to exceed its budget by in excess of \$100 million;¹⁸⁸ and
- (b) the budget for the Stage 1 of the QPMH (which included the Redlands project) included \$27 million plus GST for which no approval had been obtained (Governor in Council approval having not been sought or obtained).

5.78 The evidence reveals that the new government sought savings in order of \$100m to \$120m to bring the expenditure of the Health Department back within its budget.¹⁸⁹ But the evidence also shows that appropriate processes were put in place to ensure that the saving strategies were clinically appropriate, and did not cause any loss of services. In particular, a '*Budget and fiscal examination Committee*' was formed. The group included Dr Cleary, a Deputy Director-General, and Dr Young, the Chief Health Officer, and reviewed the savings strategies and made recommendations on what strategies could be put in place.¹⁹⁰ Dr Cleary explained that '*The focus of the group was to ensure any savings were clinically appropriate.*'¹⁹¹

Conclusions as to decision to cease Redlands facility

5.79 It is submitted that there is no proper basis to criticise the decision that was made to cancel the Redlands project in May 2012, in circumstances where:

- (a) the clinical thinking behind a single, Statewide, extended inpatient adolescent facility, as was contemplated for Redlands, was considered out-dated and not appropriate by that section of Queensland Health which had the relevant expertise and accountability, being the MHAODB (and there is considerable evidence before the Commission that this opinion was not only reasonably open, but that it is indeed the better view);

¹⁸⁵ Statement of Dr Young (EXH.00186), CHS.900.005.0001 at .0022.

¹⁸⁶ QHD.007.002.1462 (EXH.00265) at .1463, paragraph 15.

¹⁸⁷ By email dated 10 March 2016 from McCullough Robertson, to the Executive Director of the Commission, Mr Springborg requested any Governor In Council, or CBRC, submission or approval, between Sept 2011 and March 2012, seeking or giving approval for the increase from \$122m to \$148.3m funding for stage 1 of the QPMH, as discussed in para 14 and 15 of the Sept 2011 briefing note [QHD.007.002.1462 (EXH.00265)]. By a letter dated 15 March 2016, the Commission identified document DPC.003.001.0001 as the only document relevant to the request. That document, dated 19 September 2011, does not record any Governor-in-Council approval being sought or obtained. The inference is that no Governor-in-Council approval was ever sought or obtained.

¹⁸⁸ T12-18:5-17.

¹⁸⁹ It should be noted that the Health Department's budget was not reduced by the new government. Rather, there was a need to ensure that expenditure did not exceed that budget: T15-9:44-45 (Mr Springborg); T12-16:14-21 (Dr O'Connell).

¹⁹⁰ T14-12:16-18 (Dr Cleary).

¹⁹¹ T14-12:19-21 (Dr Cleary).

- (b) this view was communicated to and accepted by the Chief Health Officer for Queensland, and by the Director-General for Queensland Health;
- (c) there were practical problems and delays over four years which meant that as by 2012 (i) the Redlands project was considered to be not viable, (ii) a new facility at Redlands could never provide a solution to the looming problem created by the redevelopment of The Park, and particularly EFTRU; and
- (d) ceasing the Redlands project would have no impact on the provision of patient care, because the BAC was continuing to operate.

Submissions of Counsel Assisting as to the decision to cease the Redlands project

5.80 Counsel Assisting submit that there was inadequate consideration of the merits of ceasing Redlands before the May 2012 decision was made.¹⁹² During the oral hearing, many questions from Counsel Assisting focussed on an asserted lack of written analysis or reports, an asserted lack of consultation, and an assertion that no expert opinion was obtained. For example, Counsel Assisting points to Dr O'Connell's concession that there was nothing in the briefing note he signed on 16 May 2012 that referred to further background information or expert reports, and that he did not question the relevant signatories to the brief because it was logical and consistent with the conversations he had been having over the course of the preceding months.¹⁹³ Counsel Assisting refers to Dr Kingswell's view that the proposed model for Redlands was outdated with reference to the draft *National Mental Health Service Policy Framework (NMHSPF)*, but contend that no expert advice or document or report records that view.¹⁹⁴ Counsel Assisting says that the NMHSPF is in some ways inconsistent with that theory, was only in draft form, and had not been reviewed by Dr Cleary nor Dr Stathis.¹⁹⁵

5.81 However:

- (a) no expert evidence was called that Dr Kingwell's understanding of the NMHSPF was wrong, and indeed, no expert was called to opine on the meaning of the NMHSPF;
- (b) the critique just noted ignores the long professional discourse, referred to in paragraphs 5.16 to 5.27 above, which had been occurring over many years both in relation to mental health generally and the BAC specifically, which favoured a move away from the BAC model to more decentralised, non-institutional and community-based service delivery. The level of documentation required to support a decision arising out of a long-term and well-known national policy development will be much less than that required to support a novel or 'van guard' decision. As Dr O'Connell explained:¹⁹⁶

'Well, if those subordinate to you were advising you that a project such as Redlands should cease and that one of the reasons, indeed, one of the critical reasons why it should cease was that the model of care was no longer in step with thinking amongst psychiatrists, I'm asking you in what depth you would've expected them to have researched that question before summarising the results in that way. Do you understand my question? --

¹⁹² Submissions of Counsel Assisting, paragraph 184 and 196 and Table No. 4C: Reasons for Closure, COI.028.0001.0225.

¹⁹³ T12-19; T12-18:34-44; Table No. 4C: Reasons for Closure, COI.028.0001.0225 at .02231.

¹⁹⁴ T12-19; T12-18:34-44; Table No. 4C: Reasons for Closure, COI.028.0001.0225 at .02231; Submissions of Counsel Assisting, paragraph 184.

¹⁹⁵ Submissions of Counsel Assisting, paragraphs 191-194; T14-11:4-5 (Dr Kingswell).

¹⁹⁶ T12-52:24-37.

Yes, I do. My answer is: not as much depth as I think your question implies. And the reason is that this sense of the model of care is changing was something which was becoming more obvious in many quarters. And, as I said, had already been encapsulated in the main mental health plans for both the country and for the state, that we were changing the way we were approaching the management of people with severe – even severe mental illness from more of a community – from an institutionalised approach to more of a community based approach. So it went without saying that the model of care was changing.'

- (c) the decision to cease Redlands did not extend to a decision about the services that would in due course be provided following a closure of the BAC (and the decision to cease Redlands, as recorded in the May 2012 briefing note, expressly noted there would need to be a further review to answer this question);
 - (d) MHAODB had considerable expertise, including highly qualified psychiatrists in Dr Kingswell and Dr Gilhotra;
 - (e) as discussed in paragraphs 5.22 to 5.62 above, the preponderance of professional expert opinion either positively supports a move away from service delivery of the kind contemplated by BAC or the Redlands facility, or acknowledges there is no satisfactory evidence to support such a model of care – and critically, all of those within the Department or Mental Health Branch were convinced that Redlands was not clinically appropriate; and
 - (f) there is no evidence from an expert in public health administration or policy development to the effect that the decision-making process was inadequate. Without such evidence, there is no proper basis to criticise the decision-making. A lawyer might think further documentation should have been prepared. However a lawyer's view is not a sound basis from which to judge the development of public health policy.
- 5.82 Thus, no evidence supports the view that there was inadequate consideration of the decision, and there is substantial evidence to suggest that the correct decision was made (or at the very least a decision which, while professional minds may differ, was clearly open and reasonable).
- 5.83 As to the Minister: he was entitled to rely on Department's advice that it was appropriate to cease the project. The advice was provided by some of the State's most senior clinicians, including the Chief Health Officer. Indeed, it is difficult to see what proper basis the Minister would ever have had to gainsay the advice of his Department.

Submissions of Counsel Assisting as to the approval of the August 2012 Briefing Note

- 5.84 As noted in Part 2 above, Counsel Assisting's written submissions criticise the decision encapsulated in the August 2012 Briefing Note signed by the Minister, as having been made:¹⁹⁷
- (a) without documents, reports or advice recording that the Redlands project was not the appropriate model of care; and
 - (b) with limited consultation, which must have made it difficult to perform a balancing exercise which assessed the competing demands for the \$41 million in taxpayers' money.
- 5.85 Counsel Assisting also submit that decision to allocate funds to the rural hospital infrastructure needs was likely to be a "political decision", made by the Minister without any analysis or balancing of competing demands. They further submit that the Minister made the decision

¹⁹⁷ Submissions of Counsel Assisting, paragraph 203.

without any advice from Queensland Health¹⁹⁸ and without any consideration of the consequences for the four cancelled or deferred projects.¹⁹⁹

- 5.86 These criticisms are without basis and should be rejected.
- 5.87 **First**, the purpose of the August 2012 briefing note was, as is apparent from the face of the document, not to decide whether to cease the Redlands project. That decision had been made three months earlier, in May 2012.
- 5.88 Instead, as is apparent from the face of the document itself, the August 2012 briefing note asked the Minister to approve the planned strategy for targeted rectification of prioritised infrastructure issues, and to note the recommended \$41million funding strategy of ceasing three projects (including Redlands) and deferring a fourth.
- 5.89 Mr Springborg testified that he had become aware of an earlier report in relation to 12 rural hospitals that required immediate funding to addresses serious issues, such as fire safety, health and safety and access, that if neglected any longer, threatened the closure of the hospitals.²⁰⁰
- 5.90 It was appropriate to note the source of the funds, so the Minister could be assured that the source of funds was appropriate. But at least in the case of Redlands, it was enough to know that the funds were being reallocated from a project that had already been assessed as one which – primarily because its proposed model of care was not considered appropriate – did not merit progression. The Briefing Note to the Director-General of 10 August 2012 that was attached to the Ministerial Briefing Note expressly records:²⁰¹
- 'Dr Bill Kingswell, Executive Director – Mental Health, Alcohol and other Drugs recommended the cessation of the replacement Adolescent Extended Treatment Unit at Redlands...'*
- 5.91 It is submitted that the Commissioner would accept that a project which has already been assessed as suitable for cancellation because it embodies an inappropriate model of care, and that was plagued by site issues that had led to gross delays, cannot be said to more deserving than urgent hospital repairs, assessed as being needed to permit their continued operation (particularly when patient care is unaffected because the BAC continued to operate): or at the very least, the decision in the August 2012 Briefing Note, was one that was reasonably and properly open to the Minister to make.
- 5.92 Further, it is submitted that the Commissioner would conclude that nothing had changed between May 2012 and August 2012 to suggest that the May 2012 decision to cease the Redlands project should be revisited (and there is no evidence that anyone within the Department considered that it should be, or that the Minister was ever asked to himself consider whether it should be).
- 5.93 It is submitted, further, that the Commissioner would conclude that it is appropriate to re-allocate capital funding notionally allocated to a project that had been cancelled. Given the scarcity of public resources, a government could rightly be criticised for leaving idle funds nominally allocated to a now ceased project – the alternative being, of course, that fresh funding was required from some other source.

¹⁹⁸ The submission that the decision was made without advice from Queensland Health is, with respect, particularly absurd. Even putting aside the 2010 report which identified the rectification needs, the August 2012 briefing notes are themselves advice from the Department.

¹⁹⁹ Submissions of Counsel Assisting, paragraph 204.

²⁰⁰ T15-4:45 to T15-5:7.

²⁰¹ Statement of L Springborg, (EXH.00120), exhibit LJS-3

5.94 As Mr Springborg said:²⁰²

'Through Dr Young and Dr Kingswell and Dr O'Connell they had already made a decision around the cessation of the Redlands project well and truly prior to this [August 2012] and so it's of no surprise to me that that has formed a part of the options available to us.'

5.95 **Second**, and in any event, contrary to the submissions of Counsel Assisting, it is clear that a cost-benefit analysis had indeed occurred. The August 2012 briefing note to the Minister states that:

- the proposal involved '*minimum expenditure for targeted prioritised infrastructure rectification to improve safety and functionality in the short term*'; and
- the '*[f]unding strategy relates to cessation and/or deferral of projects for replacement/collocation of existing services and not service expansion.*'

5.96 In other words: only rectification immediately needed for short term safety and functionality is being proposed (the need is great and immediate), and the funding is being sourced from deferred or cancelled projects which were replacing (not expanding) existing services, so there will be no reduction in services to the public.

5.97 The recommendation itself followed a Preliminary Evaluation (see paragraph 4 of the briefing note to the Director-General) which identified 3 options for addressing the issue. These are apparently described in Attachment 1 to the note, but this document has not been provided to Mr Springborg by the Commission, nor have Counsel Assisting's submissions considered it. The option recommended, option 1, involved only undertaking the immediate and urgently needed repairs to ensure continued short term operation of the hospitals.

5.98 Accordingly, Counsel Assisting criticise an asserted lack of analysis on the part of decision-makers, but have made no attempt to analyse the very document containing the recommendation.

5.99 Nor is there any evidence of the content of the 2010 report, which had clearly been considered by those who prepared and approved the August 2012 briefing note. This report is not in evidence, and Mr Springborg was not asked anything about it. This is extraordinary given Mr Springborg's evidence.²⁰³

'The motivation to need to find this money was a report which was discovered by my office into the significant neglect of 12 hospitals. They just happened to be in regional areas, which such major issues such as fire safety, other health and safety issues, access issues. And we needed to address that immediately, because there was a serious issue as to whether those hospitals would be able to continue to operate.'

5.100 Counsel Assisting also contend that there was a failure to consider the consequences of cancelling the Redlands project,²⁰⁴ but fail to identify any adverse consequence, or even why there might be such consequences. No patient care would be compromised, because the service at BAC continued.²⁰⁵ The Redlands project had made virtually no progress in four years. Development approval had not even been obtained. Notwithstanding the project started in 2008, on a best case it was, as at May 2012, still two years away from completion. Counsel Assisting's submissions seem content to accept uncontroversial but generic statements that capital projects

²⁰² T15-7:3-6.

²⁰³ T15-4:45 to T15-5:3.

²⁰⁴ Submissions of Counsel Assisting 203(b).

²⁰⁵ It is notable that when Dr Kingswell made this point in evidence, Counsel Assisting did not challenge him on it or otherwise identify any potential adverse consequence: T13-18:12-17.

often encounter delay, but fail in any meaningful way to examine the extent of the delay in the Redlands project. Its delay had clearly gone well beyond what was normal or acceptable, to the point where the Health Department sought external advice from Savills in an effort to expedite it.

- 5.101 In contrast to the lack of adverse consequences from cancelling Redlands, it should be inferred there could have been serious adverse consequences if the rectification work were not performed on the 12 hospitals.
- (a) A report from 2010 had identified the infrastructure issues at the hospitals, but no action had been taken to address the issues since that time.²⁰⁶
 - (b) The proposed rectification works addressed '*infrastructure risks for continuity of existing services*' and were '*targeted to the higher risk areas of the relevant building codes, for example, fire safety, electrical*'.²⁰⁷ The proposed works '*targeted prioritised infrastructure rectification to improve safety and functionality in the short term*'.²⁰⁸
- 5.102 The natural implication is that the short term safety and functioning of the hospitals was in danger unless the works were undertaken. Mr Springborg's unchallenged evidence is that there was a '*serious issue as to whether those hospitals would be able to continue to operate*'.²⁰⁹ The Commissioner would regard it as uncontroversial that for a rural hospital to be at risk of being unable to safely operate because of neglected infrastructure issues, could properly be regarded as entirely inappropriate.
- 5.103 **Third**, implicit in the criticism is the notion that reallocation of the Redlands funds also involved a decision to the effect that no funds would be available for a new build, even if that was the recommendation that arose from the review with respect to the BAC replacement. But that simply is not the case. Nothing in either the May 2012 or August 2012 briefing note suggests that. Persons within the Department or West Moreton may have assumed such a decision to have been made, but it was a wrong assumption, and one that was never raised with the Minister. The evidence of Mr Springborg is that had such a new build been recommended to him, the money was available.²¹⁰ In fact, surplus funds were available in the 2012/2013 and 2013/2014 years.²¹¹ The willingness of the Health Department to spend on new initiatives as part of the development of the new AETR services in late 2013 and throughout 2014²¹² corroborates Mr Springborg's evidence in this regard.
- 5.104 **Conclusions – criticisms of August 2012 briefing note** Counsel Assisting's criticism of the Minister's approval of the August 2012 briefing note should be rejected.
- 5.105 The inflammatory and emotive assertion in paragraph 204 of Counsel Assisting's submissions – that the Minister's decision was purely political, and made without any analysis and devoid of any advice from the Department - is unsupported by evidence, and is contrary to the evidence. It was, as well, never put to Mr Springborg, who has not had the chance to respond to it. The submission is unfortunate, and ought never to have been made.

²⁰⁶ T15-4 to T15-5.

²⁰⁷ August 2012 briefing note to the Director-General, paragraphs 4 and 8.

²⁰⁸ August 2012 briefing note to the Director-General, paragraph 2.

²⁰⁹ T15-5:2-3.

²¹⁰ Statement of L Springborg (EXH.00120), paragraph 71, 74, 140 to 142; T15-4:15-30. Mr Springborg's evidence in this regard is consistent with the instructions provided to him as Minister in the Charter letter from the Premier, which instructions included a direction to "identify wasteful expenditure that can be redirected to frontline services": see LJS1 at LJS.900.001.0001 at .0029-.0030.

²¹¹ T12-85:45 to T12-86:13.

²¹² T12-86:4-13.

'Third decision' – the closure of BAC notwithstanding Redlands was not proceeding

(1) August 2012 to November 2012

- 5.106 There is substantial evidence of relevant discussions and decisions between August 2012 and November 2012 that were occurring within the Department, and below the level of the Minister and his office. This is as the Commissioner would expect.
- 5.107 Dr Kingswell gives evidence that on 4 September 2012, he met with a Deputy Director-General (he does not specify who, but it is likely to be Dr Cleary), and advised that the BAC should be closed and replacement services developed.²¹³
- 5.108 This is confirmed by an email exchange he had later that day with Dr Terry Stedman (who was Director of Clinical Services at The Park), in which Dr Kingswell says that his advice to the Deputy Director-General *'was that we should close [BAC] and develop replacement services both day centres and NGO respite.'*²¹⁴
- 5.109 The foregoing is consistent with the May 2012 briefing note, which had foreshadowed (at paragraph 7) a review into the appropriate model of care would be necessary.
- 5.110 Ms Dwyer gives evidence that on 11 September 2012, she met with Dr Kingswell and Dr Cleary at BAC. She says that during this meeting Dr Kingswell told her that an alternative service model should be directed to a contemporary model of care provided to patients in their local area rather than a State-wide single site.²¹⁵
- 5.111 On 25 October 2012, there was a meeting at MHAODB between Ms Kelly, Dr Kingswell, Dr Geppert and Dr Gilhotra. At the meeting, the MHAODB attendees said that
- 'the BAC service as it existed at that time, being a bricks and mortar residential and education long stay facility with a State-wide catchment, was not considered by MHAODB to be part of the service model for the delivery of adolescent mental health services going forward.'*²¹⁶
- 5.112 Ms Kelly then told Ms Dwyer about this meeting.²¹⁷
- 5.113 Dr Kingswell does not recall either of these conversations specifically, but does say that he had numerous conversations with Ms Dwyer and Ms Kelly about the matter. Dr Kingswell does not recall discussing these matters with the Minister.²¹⁸ The Commissioner should find that it is unlikely that he did, but that Dr Kingswell's views were conveyed to the Minister, probably via Dr Cleary and/or Dr O'Connell.
- 5.114 On 26 October 2012, Ms Dwyer received an email from Ms Kelly (Executive Director of Mental Health Special Services WMHHS) which stated that a brief had been given to the Minister regarding BAC. The brief *'did not clearly articulate that closure as the only option, however...the model for BAC is not aligned into the future planning for The Park or for Queensland Mental Health Plan.'*²¹⁹ It seems this brief was not ultimately sent: there is no evidence that such brief was ever sent to the Minister's office.

²¹³ Statement of Dr Kingswell (EXH.00068), paragraph 19.

²¹⁴ Statement of Dr Kingswell (EXH.00068), paragraph 19; DBK.900.001.0093.

²¹⁵ Statement of Lesley Dwyer (EXH.00049), paragraph 5.5.

²¹⁶ Statement of S Kelly (EXH.00066), paragraph 9.2 to 9.6.

²¹⁷ Statement of S Kelly (EXH.00066), paragraph 10.2 to 10.3.

²¹⁸ Statement of Dr Kingswell (EXH.00068), paragraph 19.

²¹⁹ Statement of Lesley Dwyer (EXH.00049), paragraph 5.10.

5.115 However, a record of the thinking of the time is found in the email on 8 November 2011 from Ms Kelly to 'SDLO' (a senior departmental liaison officer) and a Ms Waller, which notes 'pertinent points' regarding the consideration of the BAC then occurring. The points included (emphasis added):²²⁰

- ***'There is a clear national and State policy direction to ensure that young people are treated close to their homes in the least restrictive environment with the minimum possible disruption to their families, educational, social and community networks.'***
- ***The National Mental Health Service Planning Framework currently being developed by the Commonwealth Government due for completion in July 2013 does not include provision for non-acute adolescent inpatient services as per the current model at Barrett. The Framework does include subacute community based services for adolescents.***
- *Planning is required to align with the National Mental Health Service Planning Framework that recommends subacute community based services for adolescents.*
- *The deinstitutionalisation of services currently provided at The Park Centre for Mental Health is part of the reform agenda under the Queensland Plan for Mental Health 2007-20017 (QPMH) and will result in only forensic and secure services being provided at the facility by July 2013.*
- ***Concerns have been raised about the co-location of Barrett Adolescent Centre (BAC) with adult forensic and secure services delivered by TPCMH.***
- *The BAC delivers an extended treatment model of care that consists of both extended inpatient and day patient programs including education components.*
- *Under the QPMH, it was determined that the development of a new model of care for BAC was required.*
- *The Redlands Adolescent Extended Treatment Unit (RAETU), funded under the QPMH, was intended to replace BAC. This project has ceased due to unresolved environmental issues and budget overruns and hence is no longer a sustainable capital works project for Queensland Health.*
- *Recent sector advice proposes a re-scoping of the BAC service model and governance structure to ensure a contemporary evidence based model of care is being provided for adolescents with serious mental illness.*
- *The average bed occupancy rate for BAC is 43%. This is less than half of the 15 beds currently available in this unit.*
- ***The age and condition of the building has been identified by the Australian Council on Healthcare Standards as unsafe, necessitating urgent replacement.***
- *Alternative services for this group of consumers will need to be considered immediately and will require a collaborative approach...'*

²²⁰ DZM.001.001.0100.

- 5.116 In late 2012 WMHHS formulated a Barrett Adolescent Strategy Project Plan (**Project Plan**).²²¹ The purpose of the Project Plan was to articulate the steps required to achieve the development of alternative contemporary stateside model(s) of care, as well to develop an implementation plan to achieve that alternative model.²²²
- 5.117 The Project Plan required the approval of the West Moreton Board. It was tabled by Ms Dwyer at the Board meeting on 23 November 2012.²²³
- 5.118 In late 2012, WMHSS established a Planning Group, whose role it was to undertake a review of the appropriate model of care, make recommendations to the West Moreton Board, and plan for the closure of the BAC and the implementation of the new model. In turn, the Planning Group established the ECRG
- 5.119 The Project Plan included the establishment of the ECRG to consider alternative models of care, and a Planning Group. The ECRG would report to the Planning Group, which would report to Ms Dwyer as chief executive of WMHHS. Ms Dwyer would in turn report to the West Moreton Board, and the Director-General.²²⁴

(2) December 2012 to May 2013

- 5.120 On 14 December 2012, WMHHS representatives (Dr Corbett, Ms Dwyer, and Ms Kelly) met with the Minister. The need to develop an alternative contemporary State-wide model of care was discussed.²²⁵ It is likely that at this meeting the WMHHS representatives discussed with Mr Springborg that EFTRU was proposed to open in 2013, and the increased risk that EFTRU posed to the BAC patients.²²⁶
- 5.121 From late 2012 to May 2013:
- (a) the ECRG met and provided a report and recommendations to the Planning Group;
 - (b) the Planning Group considered the ECRG report, and made its own recommendations. In doing so it accepted all of the ECRG recommendations, although for some of the recommendations it did so with qualifications or caveats;
 - (c) the West Moreton Board considered the recommendations of the Planning Group.
- 5.122 The Project Plan assumes that BAC would not stay open, nor would an alternative facility be developed. Specifically, the Project Plan states, under the heading 'Out of Scope', that *'As there is no longer a current capital allocation to rebuild BAC on another site, the model(s) of care to be developed must exclude this as an option.'*²²⁷
- 5.123 From Mr Springborg's perspective, this statement is incorrect. It was not the position of the Minister or his office. Cessation of Redlands did not mean that capital would not be available in future if a new capital project was recommended: funds would have been made available if a new build had been recommended to the Minister.²²⁸ This evidence is not contradicted and should be accepted.

²²¹ Statement of S Kelly (EXH.00066), paragraph 10.5, SK 10; WMS.0012.0001.14639 (EXH.00066) (WMS.9000.0006.0082).

²²² WMS.0012.0001.14639 (EXH.00066) at 14640.

²²³ Statement of Dr Corbett (EXH.00041), MC-17; WMB.1000.0001.00032.

²²⁴ Statement of Lesley Dwyer (EXH.00049), paragraph 5.13.

²²⁵ Statement of Dr Corbett (EXH.00041), paragraph 14.5; WMB.1000.0001.00145 (WMB.9000.0001.00072).

²²⁶ Supplementary Statement of L Springborg (EXH.00214), paragraphs 3 to 4, paragraphs 9 to 10; T15-30:6-40.

²²⁷ WMS.0012.0001.14639 (EXH.00066) (WMS.9000.0006.0082) at 14640 (0083).

²²⁸ Statement of L Springborg (EXH.00120), paragraph 71, 74, 140 to 142; T15-4:15-30; T15-8:35-39.

- 5.124 It appears that WMHHS was operating on an incorrect assumption, at least so far as the Minister was concerned. Of course, the advice that no capital funding was available may have been provided by Dr Kingswell, on the basis that he and the Mental Health Branch would not support a funding submission for new facilities like BAC. In any event, no one from West Moreton verified this issue with Mr Springborg or his office.²²⁹ In fairness to West Moreton, however, it may well be that this issue was considered to be something below Ministerial level (and so there was no occasion to ask the Minister's office for its view): there is no good evidence as to who with the Department of Health a funding submission or budget request would be made to.
- 5.125 In the event, this assumption in the Project Plan as to the absence of a capital budget did not prevent the ECRG from considering the desirability of what it described as Tier 3 services. Dr Geppert, who chaired the ECRG, gives evidence of lengthy debate and discussion about the necessity and principles of Tier 3 services.²³⁰ This is supported by the evidence of other members of the ECRG.²³¹

(3) The ECRG

- 5.126 The evidence is that the purpose of the ECRG was to provide expert clinical advice to promote the development of contemporary evidence-based models of care to meet the needs of adolescent mental health consumers who experience severe and persistent psychiatric symptoms that significantly interfere with social, emotional, behavioural and psychological functioning and development.²³²
- 5.127 Dr Geppert, who chaired the ECRG, explained that it was not the role of the ECRG to develop a precise model of service that could be implemented.²³³ She said that the ECRG's role was '*more of a systemic approach and the aim was to recommend the broad components of a service continuum for patients in this particular cohort across Queensland*'.²³⁴
- 5.128 The ECRG report - which calls itself an 'elements document' - itself states that it is not a model of service, but is instead a conceptual document the delineates components of a service continuum. The Report states that it does not define how the key components would function at a service delivery level, and did not incorporate funding and implementation planning processes.²³⁵
- 5.129 The ECRG was chaired by Dr Geppert. Dr Geppert was the Director of Strategy, Mental Health and Specialised Services at WMHHS from May 2013, and prior to this was Director, of Planning and Partnerships Unit at MHAODB.
- 5.130 The ECRG had a broad membership and comprised of people with appropriate expertise in the field of adolescent mental health. As the Commissioner is aware, the other members of the ECRG were:²³⁶
- (a) Dr Trevor Sadler (Clinical Director BAC);
 - (b) Dr Michele Fryer (Faculty of Child and Adolescent Psychiatry);
 - (c) Dr James Scott (Consultant Psychiatrist Early Psychosis, Metro North HHS);

²²⁹ T15-4:15-30 (Springborg); T15-8:35-39 (Springborg); T10-15:26-37 (Geppert). There is no evidence that the Project Plan, a WMHSS document, was reviewed by the Minister or his office at the time.

²³⁰ Statement of Dr Geppert (EXH.00055), paragraph 5.8.

²³¹ Statement of Dr Hazell (EXH.00063), paragraph 72.

²³² Statement of S Kelly (EXH.00066), SK-11; WMS.1002.0002.00091 (WMS.9000.0006.00858).

²³³ Statement of Dr Geppert (EXH.00055), paragraph 5.9; T10-25:25-40 (Dr Geppert).

²³⁴ Statement of Dr Geppert (EXH.00055), paragraph 5.10.

²³⁵ These statements on page 2 of the ECRG report.

²³⁶ Statement of Dr Geppert (EXH.00055), paragraph 5.5.

- (d) Dr David Hartman (Clinical Director, Community Youth Mental Health Service, Townsville HHS);
 - (e) Professor Philip Hazell (Director, Infant Child and Adolescent Mental Health Services, Sydney and South-Western Sydney Local Health Districts);
 - (f) Ms Josie Sorban, (Director of Psychology, Community Youth Mental Health Service, CHQHHS);
 - (g) Ms Amanda Tilse, (Operational Manager, Alcohol, Other Drugs and Campus Mental Health Services, Mater Children's Hospital);
 - (h) Ms Amelia Callaghan (State Manager Queensland, NT and WA, Headspace);
 - (i) Ms Emma Hart (Nurse Unit Manager, Adolescent Inpatient Unit and Day Service, Townsville Hospital and Health Service);
 - (j) Mr Kevin Rodgers, (Principal of the Barrett School);
 - (k) a consumer representative; and
 - (l) a carer representative.
- 5.131 The ECRG met on a weekly basis²³⁷. It provided its final report to the Planning Group in May 2013.²³⁸
- 5.132 According to Ms Kelly, the Planning Group gave considerable weight to the views expressed by ECRG.

(4) Planning Group

- 5.133 The Planning Group settled the terms of reference for the ECRG, identified the membership of the ECRG, considered the ECRG's report, and reported to Ms Dwyer with its recommendations regarding the closure of BAC.
- 5.134 Ms Kelly chaired the Planning Group.²³⁹ Other members of the Planning Group included:²⁴⁰
- (a) Dr Kingswell (Executive Director Mental Health, MHAODB);
 - (b) Dr Geppert (Director Planning and Partnerships MHAODB);
 - (c) Dr Sadler (Clinical Director BAC);
 - (d) Mr Chris Thorburn (then Director of Strategy Mental Health and Specialised Services);
 - (e) Dr David Hartmann (Clinical Director, Community Youth Mental Health Service (CYMHS), Townsville Hospital and Health Service);
 - (f) Dr Stephen Stathis (Psychiatrist, Child and Family Therapy Unit, Children's Health Queensland); and

²³⁷ WMB.1000.0001.00005.

²³⁸ Statement of S Kelly (EXH.00066), exhibit SK-14; WMS.1000.0045.00014 (WMS.9000.0006.00886).

²³⁹ Statement of S Kelly (EXH.00066), paragraph 11.2.

²⁴⁰ Statement of S Kelly (EXH.00066), paragraph 11.4.

- (g) Representative from Royal Children's Hospital School and a communications consultant.
- 5.135 It is apparent that the Planning Group comprised persons with considerable expertise in both clinical care and public health administration. Importantly, and unlike the members of the ECRG, these persons were all employees of the Department of Health, or a relevant HHS. They were, accordingly, more intimately and directly involved in the practical application of any recommendation made by the ECRG, and with the practical issues that affected the continued operation of the BAC at The Park.
- 5.136 The evidence is that in considering the ECRG Report and making recommendations, the Planning Group considered a wider range of factor than the ECRG. In particular, the Planning Group considered issues such as the risks associated with keeping the BAC open, and weighed them against the risks identified by the ECRG from closing the BAC before the new statewide model of care was fully implemented.²⁴¹ It would therefore be quite wrong to consider the ECRG Report as the only input into the Planning Group's deliberations, or to regard the Planning Group as simply being an administrative body.
- 5.137 The collective views of the experts who sat on the Planning Group were reflected in the Planning Group Recommendations.²⁴² That document was presented to the WMHHS chief executive, Ms Dwyer. Ms Dwyer then presented it to the West Moreton Board, at its meeting on 24 May 2013.²⁴³ She also briefed the Director-General in relation to it.²⁴⁴
- 5.138 Relevantly, in relation to the ECRG's recommendation about a Tier 3 service, the Planning Group's view was that *'Further work is needed to detail the service model for a Tier 3. Models involving a statewide, clinical bed-based service (such as the Barrett Adolescent Centre) are not considered contemporary within the National Mental Health Service Planning Framework (in draft).'*²⁴⁵

(5) West Moreton Board

- 5.139 The West Moreton Board considered the Planning Group recommendations at its meeting on 24 May 2013.
- 5.140 The Agenda paper for the meeting states:²⁴⁶
- '3. A Planning Group has oversighted an ECRG of senior child and youth mental health experts to develop a Service Model Elements document according to the project plan.*
- 4. Membership of the ECRG included multidisciplinary clinicians, a consumer representative, a carer representative, an inter-state clinician, and a representative of the Department of Education, Training and Employment. The ECRG met between 1 December 2012 and 24 April 2013.*
- 5. The Park is designated to become an adult secure forensic facility within the Queensland Plan for Mental Health 2007-17. This process will progress to the next stage when the Extended Forensic Treatment and Rehabilitation Unit opens on 28 July 2013. The provision of adolescent*

²⁴¹ T11-77:8-22; T10-15:26-37 (Geppert).

²⁴² Statement of S Kelly (EXH.00066), paragraph 11.17, exhibit SK-15; WMS.1002.0002.00079 (WMS.9000.0006.00001 at .00892).

²⁴³ Statement of Dr Corbett (EXH.00041), MC-19; WMB.1000.0001.00049 (WMB.9000.0001.00145).

²⁴⁴ Statement of L Dwyer (EXH.00049), paragraph 5.13; Statement of M Cleary (EXH.00040), paragraph 84(vii) – (viii).

²⁴⁵ Statement of S Kelly (EXH.00066), Exhibit SK-12; WMS.9000.0006.00877.

²⁴⁶ Statement of Dr Corbett (EXH.00041), MC-19; WMB.1000.0001.00049 (WMB.9000.0001.00145).

services within the future forensic environment is not considered appropriate or safe, and poses a potential risk to adolescent consumers.

6. *The current BAC is an aged facility that has been designated not-fit-for-purpose in the provision of inpatient services into the future. The state-funded capital project to build a replacement facility for BAC in Redlands has ceased due to unresolvable building and environmental barriers, and none of this capital funding is available to build the facility elsewhere.*

Key Issues or Risks

7. *The ECRG submitted a Preamble and the Service Model Elements of an Adolescent Extended Treatment and Rehabilitation Services document (refer Attachments 1 and 2) to the Chair of the Planning Group on 8 May 2013. These documents were reviewed by the Planning Group on 15 May 2013.*

8. *The Planning Group accepted all recommendations of the ECRG, with some caveats for note (refer Attachment 3).*

9. *The Service Model Elements document (and the associated recommendations for an alternative model of service) allows for the safe and timely closure of BAC.*

10. *Given 10 out of 16 young people from the current BAC inpatient group are aged 17 years or over, and that the length of stay is up to two years in several cases, it is considered clinically adequate to provide a four month time frame to complete discharge planning and aim to close BAC 30 September 2013.*

11. *The closure of BAC is not dependant on the next stages of progressing and consulting on a statewide service model; instead, the closure process is relevant to the needs of the current and wait-list consumer group of BAC, and the capacity for 'wrap around' care in their local community services. The Planning Group noted this was feasible to commence now.'*

5.141 The evidence is that the Board took all of these issues (and not just the reports of the ECRG and the Planning Group) into account when making its decision.²⁴⁷

5.142 In particular, the board considered the risks posed to the BAC cohort by the opening of EFTRU, and this consideration contributed to the board's decision to progress with the closure of the BAC as soon as possible. Dr Corbett's evidence is that:

"When it became apparent that the opening of EFTRU was imminent but a number of patients remained at BAC, I recall there was discussion at the Board to the effect that this situation was not ideal, however the Board reiterated that the safe care of the adolescents was of primary importance. To that end, it was anticipated that the cross-over period would be short and that the initial cohort of patients to be accommodated at EFTRU would be small in number and chosen from an extremely conservative risk assessment process to minimise risk. In those circumstances, whilst co-location of EFTRU and BAC was not considered acceptable in any long term sense, it was considered lower risk for that short period, than prematurely discharging or transitioning BAC patients."

5.143 While not a member of the Board, it is convenient at this point to note Ms Dwyer's evidence on this issue:²⁴⁸

²⁴⁷ T9-26:10-30 (Mr Eltham), T9-59:10 to T9-60:10 (Dr Corbett).

²⁴⁸ Statement of Ms Dwyer WMS.9000.0032.00001 at .00006 (para 2.9).

"The risks associated with the opening of EFTRU in the vicinity of BAC was a matter under the active consideration of the executive team of the WMHHS Mental Health and Specialised Services team. It was one of the reasons that indefinite delay in closing BAC was not considered a viable option."

5.144 The May 2013 Board minutes record the Board decided:²⁴⁹

'5.1 Barrett Adolescent Centre

Sharon Kelly, Executive Director Mental Health and Specialised Services, joined the meeting. The Board discussed the recommendation from the Planning Group that proposes the closure of the Barrett Adolescent Centre (BAC) and the issues that this presents. The Board recognised that the Barrett facility is no longer suitable but is concerned that there is currently no alternative for consumers.

The Board noted the recommendations of the Barrett Adolescent Strategy Planning Group, and the need to move as rapidly as possible to an alternative model based on those recommendations.

ACTION: Minister to be updated regarding proposed closure, plan for development of alternatives and community engagement strategy.

ACTION: Minister's approval to be sought to not accept any further patients into BAC.

ACTION: WMHHS to engage with Children's Health Services and the Mental Health Alcohol and Other Drugs Branch re planning for future model of care.

ACTION: WMHHS to pursue discharge of appropriate current patients with appropriate 'wrap around' services.

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

5.145 However, the Commission should find that the Board resolved in the terms set out in the subsequent briefing note to the Minister, of July 2013. As set out below, that Briefing Note states as follows:

"the West Moreton Board considered the recommendations of the Expert Clinical Reference Group, on 24 May 2013, and approved the closure of the Barrett Adolescent Centre dependent on alternative, appropriate care provisions for the adolescent target group and the meeting with the Minister for Health".

5.146 Before leaving the Board, it should be noted that specific strategies were implemented by WMHHS to mitigate risk during the short period in which both EFTRU and the BAC were operating. These strategies were reported to the Board in the August 2013 agenda paper:²⁵⁰

Risk management of service whilst EFTRU has opened and adolescents remain on campus

a. Extended Forensic Treatment and Rehabilitation Unit opened to first consumers 29 July 2013.

²⁴⁹ Statement of Dr Corbett (EXH.00041), MC-20; WMB.1000.0001.00012(WMB.9000.0001.00169).

²⁵⁰ WMB.9000.0004.00001 at .00007-.00008.

- b. *First tranche of consumers was direct transfer from the Extended Treatment Rehabilitation unit, already locate on the premises. (aim to test facility etc and staff learning prior to a more significant secure cohort being admitted)*
- c. *Planning for each month a further increase in consumers transferred from the High Secure unit will occur depending on their acuity and consequent full capacity anticipated by January 2014.*
- d. *Each consumer is risk assessed as to their ability to manage in the new environment.*
- e. *As a risk mitigation strategy adolescent consumers are not allowed ground access without escort during this transition phase.*

(6) The Minister

- 5.147 The Minister was not involved in the formulation of, or work of, the ECRG or the Planning Group. He was, however, aware that West Moreton had engaged an expert group to consider appropriate models of care: and was therefore advised that processes were in place to consider the delivery of services, in circumstances where it was proposed to close the BAC at some future time, and the Redlands project had been cancelled.²⁵¹
- 5.148 On 15 July 2013, Dr Corbett, Ms Kelly and Ms Dwyer met with the Minister regarding the proposed closure of the BAC and plan for development of alternatives.
- 5.149 WMHHS prepared a "Briefing Note for Noting" to each of the Minister and the Director-General regarding the meeting. A copy of the briefing note was emailed to the Minister's policy adviser, Mark Wood, on the morning of the meeting.²⁵²
- 5.150 The date stamp on the hardcopy indicates it was received by the Minister's office on 17 July 2013.²⁵³ It was signed by the Minister's principal policy adviser on 31 July 2013. The Commission did not require a statement from Mr Wood or that he attend and give evidence.
- 5.151 The briefing note to the Minister states:

'Recommendation

That the Minister:

Note *a meeting has been scheduled for 4.00pm on Monday 15 July 2013, with the West Moreton Board Chair, Chief Executive, and Executive Director of Mental Health, to discuss the next stages of the Barrett Adolescent Strategy.*

Note *the West Moreton Board consider the recommendations of the Expert Clinical Reference Group, on 24 May 2013, and approve the closure of the Barrett Adolescent Centre dependent on alternative, appropriate care provisions for the adolescent target group and the meeting with the Minister for Health.*

Note *there is significant patient/carer, community, mental health sector and media interest about a timely decision regarding the future of the Barrett Adolescent Centre. A comprehensive communication plan has been developed.*

²⁵¹ Statement of Mr Springborg (EXH.00120), paragraphs 85 to 86.

²⁵² Statement of L Springborg (EXH.00120), paragraphs 50 to 54.

²⁵³ Statement of L Springborg (EXH.00120), paragraph 50.

Note consultation about the proposed next stages of the Strategy has been limited to Commissioner for Mental Health, Children's Health Services and Department of Health.'

5.152 The briefing note is for noting only. The briefing note does not ask the Minister to approve the closure of the BAC.

5.153 The attached briefing note to the Director-General included the following statements:

'1. Urgent – There is growing concern amongst stakeholders of the Barrett Adolescent Strategy, including patients and carers, to receive communication about the future of the Barrett Adolescent Centre (BAC).

Headline issues

2. The top issues are:

- The West Moreton Hospital and Health Board considered the recommendations of the Expert Clinical Reference Group on 24 May 2013.
- West Moreton Hospital and Health Board approved the closure of BAC dependent on alternative, appropriate care provisions for the adolescent target group and the meeting with the Minister for Health.

...

8. The BAC cannot continue to provide services due to the Park becoming an adult secure and forensic campus by 2014, and because the capital fabric of BAC is no longer fit for purpose. Alternative statewide service options are required.

...

11. Agreement has been reached that the Strategy will be finalised through a partnership between West Moreton HHS, Children's Health Services, and the Department of Health.'

5.154 There is no contemporaneous record of the 15 July 2015 meeting.²⁵⁴ However, a briefing note to the Mental Health Commissioner prepared by Ms Kelly and Ms Dwyer shortly after the meeting states (emphasis added):²⁵⁵

- 'Commencing December 2012, the Strategy conducted broad consultation and planning processes pertaining to the provision of adolescent mental health extended treatment and rehabilitation care in Queensland.
- Seven recommendations made by the Expert Clinical Reference Group were considered by the West Moreton Hospital and Health Board (the Board) on 24 May 2013.
- The Board considered the recommendations and decided to approve the closure of BAC dependent on alternative, appropriate care provisions for the adolescent target group and a targeted communication process prior to public announcement.
- Consultation was most recently conducted with the Minister for Health on 15 July 2013, with his support to proceed following communication with the Director-General,

²⁵⁴ McCullough Robertson requested electronic notes made on Ministerial Office iPads by members of the Minister's staff, but the records, if they existed, were not provided.

²⁵⁵ Statement of L Schoubroeck (EXH.00130), exhibit F; LVS.001.001.0050. The briefing note records that it was cleared by Ms Kelly on 17 July 2015 and verified by Ms Dwyer on 18 July 2015.

Department of Education, Training and Employment and the Queensland Mental Health Commissioner.'

- 5.155 The Commission should find that based on the briefing he received, the Minister supported the decision to close the BAC, and communicated that to Dr Corbett and Ms Dwyer in the meeting on 15 July 2013.²⁵⁶ However, he also made clear to WMHSS that if the BAC was to be closed, adequate replacement services should be provided.²⁵⁷ Further, as will appear, the Minister was subsequently advised that:
- (a) appropriate transition arrangements were in place for the current patients admitted to the BAC; and
 - (b) CHQHHS was developing a new suite of services that were contemporary, and appropriate, and that involved a material increase in expenditure on adolescent mental health services in Queensland: see paragraph 8.1 to 8.13 below.
- 5.156 The Commissioner may recall that Mr Springborg candidly stated he had not read the ECRG report until he was preparing to attend and give evidence. However, Mr Springborg's evidence is that he was familiar with the issues in the report because they had been raised with him in his meeting with WMHHS.²⁵⁸ This is reasonable, as the report was directed to WMHHS, and it was the WMHHS that was briefing the Minister. Of course, the report had been read by those persons within WMHHS to whom it was directed, most importantly the Planning Group.
- 5.157 Moreover, significantly, in the 200 page submissions of Counsel Assisting, no complaint is made that Mr Springborg did not read the ECRG Report. Indeed, no criticism at all is directed at Mr Springborg in relation to the decision to close the BAC during 2013: see the following sections of the written submissions of Counsel Assisting: paragraphs [119] to [162] (system manager had authority to close BAC) and [163] to [269] (criticism of Minister is confined to the August 2012 briefing note; no criticism is directed at the Minister's conduct after that time).

The Commission should find that:

- (a) It was appropriate for Mr Springborg in mid 2013, on the basis of the briefings and advice he received, to support the closure of the BAC as proposed by WMHHS, during 2013.

Who had authority to close the BAC?

- 5.158 The Commissioner has requested submissions on the issues of:²⁵⁹
- (a) who had the legal authority to close the BAC; and
 - (b) who purported to exercise such authority, and on what occasion(s).
- 5.159 To answer these questions, it is necessary to consider the legislative framework under which the BAC services were provided. That framework is summarised in Appendix B.
- 5.160 First, however, it is necessary to define what is meant by "closing the BAC". In these submissions it is understood to mean a permanent closure of the BAC in circumstances where WMHHS were not intending to provide, via a means other than the physical BAC facility, a statewide adolescent extended treatment and rehabilitation service, on an on-going basis.

²⁵⁶ Statement of Mr Springborg (EXH.00120), paragraph 81.

²⁵⁷ Statement of Mr Springborg (EXH.00120), paragraph 53 to 57.

²⁵⁸ T15-33:10-15.

²⁵⁹ Email from the Executive Director dated 8 March 2016.

- 5.161 As noted in Appendix B, each HHS is required to provide those health services that are contained in the Service Agreement, which is a contract negotiated between the Service and the Director-General of Queensland Health.²⁶⁰
- 5.162 Prior to the closure of the BAC, responsibility for the provision of a statewide adolescent extended treatment and rehabilitation service lay with WMHSS. This is because that the Service Agreement between WMHSS and the Director-General (as Systems Manager) required WMHSS to provide such a service.²⁶¹
- 5.163 A decision to close the BAC, and not replace it with another service provided by WMHSS, equates with an agreement to amend the West Moreton Service Agreement to remove the statewide adolescent extended treatment and rehabilitation service from the list of services that WMHSS is obliged to provide. The persons who could make that agreement were the parties to the Service Agreement, being the Director-General (as Systems Manager) and WMHSS.
- 5.164 The Minister is not a party to the Service Agreement, nor is the Minister's consent required under the HHB Act to amend the agreement.
- 5.165 Hence, the formal decision to close the BAC was made by the Director-General and WMHSS when they agreed to amend the Service Agreement. The evidence does not reveal precisely when this agreement was reached. However the need formally to secure the Director-General's agreement may explain why the West Moreton Board minutes do not clearly state a decision to close the BAC, but rather note the Board's support for the recommendation to do so.
- 5.166 The decision was formally documented and effected in July 2014 when the WMHSS Service Agreement was amended to remove the statewide adolescent extended treatment and rehabilitation service from the list of services that WMHSS was obliged to provide.²⁶²
- 5.167 In parallel to the formal decision to close the BAC, there was another formal decision involving the Director-General and CHQHHS to the effect that CHQHHS would become responsible for the provision of adolescent extended treatment and rehabilitation services. This decision was documented and given effect with the January 2014 amendment to the CHQHHS Service Agreement, to add the Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy to the services to be provided by CHQHHS.²⁶³ In this way, there was at all times a HHS whose responsibility it was to provide statewide adolescent extended treatment and rehabilitation services.
- 5.168 Formally, there is no role for the Minister in the above process (unless the Minister felt the need to issue a directive under s44 of the HHB Act, which of its nature would be an extraordinary act, or unless the parties could not agree on the terms of the Service Agreement: s38 HHB Act). This is reflected in the fact that the relevant briefing notes to the Minister regarding the closure of the BAC were for his *noting*, and not for his *approval*. This is unsurprising in the current context because there was no change to the health services being provided, namely statewide adolescent extended treatment and rehabilitation services (AETRS). An HHS was charged to provide statewide AETRS both before (WMHSS) and after (CHQHHS) the closure of the BAC. What changed was the model of service – how those AETRS would be delivered. The decision as to the preferred model of service was a clinical issue upon which one would not normally expect a Minister to intervene or have a view contrary to the advice he or she received from the Health Department and the affected HHSs.²⁶⁴

²⁶⁰ Sections 16(1), 19(1), HHB Act.

²⁶¹ WMS.1007.0484.00021 (EXH.00228).

²⁶² LJS.002.0001.0062 (EXH.00183).

²⁶³ LJS.002.0001.0001 (EXH.00245).

²⁶⁴ Statement of Mr Springborg (EXH.00120), paragraphs 6 and 120.

- 5.169 The media release issued by WMHHS and CHQHHS on 6 August 2013²⁶⁵ is consistent with the analysis that those entities were parties to the decision about the transfer of responsibility for statewide AETRS from WMHHS to CHQHHS (the decision to close BAC being a part of this broader decision). Conversely, there was no formal announcement by the Minister, although given the importance of the issue Mr Springborg did give radio interviews on 6 and 7 August 2013 about the developments.²⁶⁶
- 5.170 Finally, while it was not a decision made by Mr Springborg, it is not suggested that Mr Springborg did not agree with the decision to close the BAC. Based on the briefings, advice and undertakings he received, he endorsed and agreed with the closure of the BAC.²⁶⁷
- 5.171 The Commission should find that:
- (a) WMHHS and the Director-General had the legal authority to close the BAC; and
 - (b) WMHHS and the Director-General purported to exercise such authority when they agreed to vary the WMHHS Service Agreement to, to remove the statewide adolescent extended treatment and rehabilitation service from the list of services that WMHSS was obliged to provide.

6 The bases for the decision to close BAC (TOR 3(b))

- 6.1 Mr Springborg has given evidence that he understood the reasons for the decision in 2013 to close the BAC were as follows:²⁶⁸
- (a) the BAC facility was ageing, and no longer safe for the patients and staff;
 - (b) the facility was located in an adult mental health facility which was going to be expanded (in particular to focus on adult forensic patients) and that expansion carried risks to the patients and staff at the BAC; and
 - (c) the BAC represented an outdated model of care that Queensland should move away from. Mr Springborg's understanding was that long-term and institutional care was no longer considered to be best practice, and that the preferred model involved caring for young people in their community and closer to home.
- 6.2 It not suggested that Mr Springborg did not have the understanding set out above during 2013, and there is no evidence to the contrary. The Commissioner should accept Mr Springborg's evidence as to his understanding of the reasons for closing the BAC.
- 6.3 It is submitted that it was appropriate for Mr Springborg, as the responsible Minister, to accept the briefings provided to him, and to support the closure of the BAC. As noted above, by 15 July 2013 the Minister had been advised that an appropriate process had been followed, with an expert group considering the clinical issues arising, and that the Planning Group²⁶⁹ and WMHSS had considered the recommendations of that group before arriving at the decision to close the BAC (see paragraph 5.141 above).
- 6.4 What was the best way of providing extended treatment and rehabilitation services to mentally ill Queensland adolescents, whether the BAC should close, and if so what should replace the

²⁶⁵ WIT.900.012.0001 (EXH.0001) at [0059]-[0060].

²⁶⁶ Statement of Mr Springborg (EXH.00120), paragraph 62; T15-36:22-41; T15-44:36-42.

²⁶⁷ Statement of Mr Springborg (EXH.00120), paragraph 81.

²⁶⁸ Statement of Mr Springborg (EXH.00120), paragraph 77.

²⁶⁹ Statement of Mr Springborg (EXH.00120), paragraph 95.

services that it provided, were all clinical matters, requiring expertise in psychiatry and public health administration. The Commissioner should, it is submitted, accept that Mr Springborg's view that it was not appropriate for him to gainsay expert advice on issues of this kind,²⁷⁰ was an appropriate and correct position to adopt. Indeed, it is submitted that it is difficult to see what other approach could be appropriate. Certainly the Commissioner would conclude that acting upon political considerations in making decisions about clinical matters is inappropriate. But the only evidence is that Mr Springborg did no such thing. The evidence is, indeed, to the contrary: Mr Springborg knew that the decision was unpopular in sections of the community, and was opposed by members of the then opposition.²⁷¹ Despite that, the Minister supported the decision as one based on expert clinical advice.

- 6.5 It is also not disputed, and there is no contrary evidence, that Mr Springborg communicated his view that there should be no gap in services if BAC closed, and that WMHHS should remain flexible as to the precise closing date for the BAC: see **Part 7** below. As is also discussed below, Mr Springborg subsequently received assurances that appropriate services had been arranged for the BAC patients prior to the closure of the BAC, and that new contemporary services were being established throughout Queensland.
- 6.6 The Commission should find that: it was appropriate for Mr Springborg, as the responsible Minister, to accept the briefings provided to him, and to support the closure of the BAC.

Counsel Assisting criticism of the decisions made by West Moreton

- 6.7 Mr Springborg's oral evidence is that he was told that BAC did not represent a contemporary model of care, and that he accepted, and at all times proceeded on the basis of, this expert advice.²⁷²
- 6.8 Counsel Assisting did not explore with Mr Springborg what he understood by "contemporary model of care". In their written submissions, Counsel Assisting suggest that the expression '*contemporary model of care*' is effectively a 'slogan' devoid of any actual content;²⁷³ a '*short hand expression*' that enabled smooth communication but lacked a sound factual foundation.²⁷⁴ That is simply wrong. The meaning of the expression 'contemporary model of care' is plain, and has been explained to the Commission by a number of witnesses.²⁷⁵ It means a model of care that:
- (a) contributes positively to the health of Queenslanders;²⁷⁶
 - (b) accords with the state and national policy documents;²⁷⁷ and
 - (c) can be comprehensively integrated with the rest of the existing continuum of care.²⁷⁸
- 6.9 As discussed above (see paragraph 2.22 and following) the weight of the expert evidence received by the Commission supports the view that the advice received by Mr Springborg on this point was correct. Before considering that evidence, it is convenient to address some of the criticism made by Counsel Assisting of the decision-making process of WMHSS and its board up to the announcement in August 2013 that the BAC would close.

²⁷⁰ Statement of Mr Springborg (EXH.00120), paragraph 96.

²⁷¹ See the evidence of Dr Cleary, at T14-48 to T14-50, and the subsequent campaign document from the ALP at QHD.006.002.8924.

²⁷² T15-26:26-34.

²⁷³ Submissions of Counsel Assisting, paragraph 192

²⁷⁴ Submissions of Counsel Assisting, paragraph 11.

²⁷⁵ Including Dr Kingswell, Dr Cleary, Dr Geppert: Transcript T10-12:1-18; T12-96 to T12-97:13-14.

²⁷⁶ T13-13 to T13-14 L15 (Dr Kingswell).

²⁷⁷ T10-12 L5 (Dr Geppert).

²⁷⁸ T10-12 L12 (Dr Geppert).

- 6.10 The criticism is summarised in the first paragraph 268 of Counsel Assisting's submissions (on page 73). That paragraph asserts that:

'The decision-making was fragmented and involved:

- (a) discussions and reasoning which was not documented;*
- (b) no proper grounding in facts;*
- (c) a lack of scrutiny of facts;*
- (d) no resort to appropriate expertise – even when a report was available; and*
- (e) a lack of proper, careful analysis of the issues.'*

- 6.11 The discussion in **Part 5** above, sets out the decision-making process actually adopted. It demonstrates that the criticisms are not well-founded.

- 6.12 **First**, the decision-making was not "fragmented". Following the decision to cease the Redlands project, it was clear that WMHSS had responsibility for conducting the review to consider what model should be adopted for AETR services going forward. WMHSS did this. It set up appropriate processes to undertake this review, by:

- (a) developing the Project Plan;
- (b) commissioning the ECRG to provide a report;
- (c) setting up an expert Planning Group which included participants from key stakeholders (in particular representatives from MHAODB and CHQ):
 - (i) to consider the ECRG report and other factors relevant to the decisions that needed to be made, such as the risks posed by the opening of EFTRU; and
 - (ii) on the basis of those considerations, make recommendations to the board;
- (d) the West Moreton board considering and adopting the Planning Group's recommendations; and
- (e) WMHSS, before implementing its decision to close BAC, briefing stakeholders on its decision, including the Director-General, the Minister and the Mental Health Commissioner.

- 6.13 Counsel Assisting have led no opinion evidence from an expert in the field of public administration, or health administration, that gainsays the process undertaken by WMHSS, described above.

- 6.14 It was at all times clear that WMHSS was the decision-maker (in the sense of being responsible for conducting the review and settling upon recommendations). Similarly, it was also clear that, with respect to implementing the decision after August 2013, that WMHSS was responsible for ensuring the BAC patients transitioned to appropriate care options while CHQ was responsible for developing and implementing statewide the precise details of the new model of service.

- 6.15 In no sense was the decision-making "fragmented".

- 6.16 **Second**, the decision and reasoning were properly documented. The briefing notes of May 2012 and the CBRC submission of June 2012 record the principal reasons for the decision to cease the Redlands project. Similarly, the Planning group recommendations, May 2013 West Moreton board Agenda paper and board meeting minutes record the reasons for the decision to proceed with the closure of the BAC. These quite clearly relate to a conclusion that the institutional model reflected in BAC and Redlands was no longer considered the preferred model (it was no longer contemporary), as well as concerns regarding the risks opening of EFTRU and the unsatisfactory state of the physical BAC buildings.
- 6.17 Counsel Assisting regard it as unsatisfactory that the parties engaged in oral discussions in addition to the briefing notes. But there is nothing inappropriate in decision-makers having oral discussions around a decision in addition to considering the written reports and briefs. Professionals constantly discuss matters with peers. It is a proper and useful way to assist communication. Again, no expert evidence has been called to gainsay this reliance on oral discussions and communication.
- 6.18 Further, there is no inconsistency between the oral discussion and the written documents. Counsel Assisting appear to take the view that, for example, Mr Springborg's recollection of being told orally in mid 2012 that senior clinicians did not regard the BAC model as contemporary is inconsistent with the content of the May 2012 briefing note.²⁷⁹ But it is not. This advice is reflected in the May 2012 briefing note that "*recent sector advice proposes a re-scoping of the clinical service model and governance structure for the Unit*".²⁸⁰ The reason to "re-scope" the clinical model was that the one then being developed was no longer considered appropriate.²⁸¹
- 6.19 **Third**, the decision was grounded in facts and properly analysed. In responding to these criticisms, it is necessary to address several points.
- 6.20 First, Counsel Assisting over-emphasise the role of the ECRG and under-emphasise the importance of the Planning Group. This is not to deny that the ECRG played an important role. However:
- (a) the ECRG was not, and was never intended to be, the body that decided the actual model of service delivery going forward or how the model was to be funded and implemented. Instead, as section 6.1 of its terms of reference made clear, its role was to provide a report to the Planning Group in accordance with the Project Plan;²⁸²
 - (b) as the ECRG report itself stated, it was a high level conceptual document. It did not define how the key components will function at a service delivery level, and did not incorporate funding and implementation planning.²⁸³ It fell to other bodies, first the Planning Group and later CHQ, to address these critical considerations;
 - (c) as noted above, the Planning Group was itself an expert group. It had considerable clinical and public administration expertise. This expertise was necessary to fulfil its role. To suggest it was merely an administrative body²⁸⁴ fundamentally misconceives its

²⁷⁹ Counsel Assisting submissions at 190.

²⁸⁰ Statement of Dr Kingswell (EXH.00068), Annexure 4; DBK.900.001.0083 (DBK.001.001.0032) at paragraph 2, first dot point.

²⁸¹ There was "significant discussion and debate about whether it was better to have a single service in a single location (such as that at The Park) with the associated dislocation of adolescents from the families or whether it was preferable to provide services throughout the State", and that the advice was "the model of care proposed at Redlands (being a single facility to serve the entire State) was out dated": Dr Young's statement at 21 and 31 (EXH.00186).

²⁸² WMS.9000.006.00001 at .00859.

²⁸³ WMS.1000.0045.00014 (EXH.00216) at .00015.

²⁸⁴ T9-44:45 to T9-45:3.

capability and role. It, and not the ECRG, was the body that reported to the WMHSS Chief Executive and, through her, the board;²⁸⁵

- (d) in making its recommendations, consistent with the respective roles of the two bodies, the Planning Group considered factors beyond only the ECRG report. In particular, it considered issues such as the risks associated with keeping the BAC open, including with respect to the opening of EFTRU, and weighed them against the risks identified by the ECRG from closing the BAC before the new statewide model of care was fully implemented.²⁸⁶ It was appropriate and indeed necessary for the Planning Group to undertake this weighing process; and
 - (e) the outcome of the Planning Group's consideration was not only recorded in its report (which recorded its recommendations against each of the Planning Group's recommendations) but also in the May 2013 WMHSS board agenda paper prepared by Ms Kelly, who was the chair of the Planning Group.
- 6.21 Second, the May 2013 Agenda paper was not inaccurate nor did it lack factual foundation, as is now contended by Counsel Assisting.²⁸⁷ It must be remembered that it was presenting the Planning Group's recommendations, and not simply seeking to summarise the ECRG report. Addressing the complaints now made by Counsel Assisting:
- (a) (Counsel Assisting's submissions at 207(a)) The Planning Group did accept all of the ECRG recommendations, albeit some were accepted with caveats. And there is no basis to say that the Planning Group was unconvinced that at Tier 3 service was not essential. It is unclear on what basis Counsel Assisting make this submission. The evidence is to the contrary. The Planning Group expressly accepted the recommendation, but made some comments on the form that this service would take. As the ECRG did not define precisely what they meant by "Tier 3", (and Dr Kingswell in particular says he remains unsure today about its meaning²⁸⁸) it is, in fact, unclear if there was any material difference between the Planning Group and the ECRG. In any event, the recommendation was acted upon by arrangements being made to have sub-acute beds available first in the Mater and later in LCCH.²⁸⁹ Indeed, consideration was given as to how to address this recommendation even before the ECRG report was finished.²⁹⁰
 - (b) (Counsel Assisting's submissions at 207(b)) In context, it is clear that the statement in the agenda paper that the Service Models document allows for the safe and timely closure of the BAC reflects the Planning Group's assessment of the Service Models document.
 - (c) (Counsel Assisting's submissions at 207(c)-(f)) Again, these report the views of the Planning Group. As previously discussed, that Group did contain clinical as well as administrative expertise. And the fact that an observation is recorded in notes as having been made by one member of the Group does not indicate that the other members disagree: indeed, the natural inference is to the contrary.
 - (d) The discussion in these submissions demonstrates that the assertions in paragraphs 210 and 211 of Counsel Assisting's submissions are not sustainable.

²⁸⁵ See the "Project Governance" and "Reporting" sections of the Project Plan, WMS.9000.006.00001 at .00831-.00832.

²⁸⁶ T11-77:8-22 (Kelly); T10-15:26-37 (Geppert); T13-41:42- T13-42:1-5 and T13-82:35-45 (Kingswell).

²⁸⁷ Cf Counsel Assisting submissions at 207-212 and 231.

²⁸⁸ T13-23:46-T13-24:2.

²⁸⁹ Affidavit of Dr Kingswell (EXH.00068), paragraph 22(ix).

²⁹⁰ Statement of Dr Cleary at 84(vi).

- 6.22 Third, part of the criticism appears to be that the West Moreton board did not independently verify the content of the reports it received from the WMHSS executives. But this misunderstands the role of a board. A board²⁹¹ of a large enterprise necessarily must rely on the information provided to it by its executives, unless there is a reason not to do so. This principle is, for example, reflected in s189 of the *Corporations Act 2001* (Cth).²⁹² It is simply not possible for non-executive boards to verify all the information provided to them. Nor, particularly when clinical decisions are involved, would be appropriate for a board to directly question clinical decisions.²⁹³ As such, much of the criticism directed at the West Moreton board for failing to verify information,²⁹⁴ or to speak directly to immediate sources of information, is unfair, and based on a fundamental misunderstanding of the proper role of a board in the position of WMHSS's board.
- 6.23 Fourth, Counsel assisting are critical of Dr Corbett and Mr Elftham's knowledge of the development of the new Statewide services.²⁹⁵ From this criticism it is said that the West Moreton board could not be satisfied that the condition it had imposed on closure of the BAC, that adequate and safe alternative services were available to the patients, had been satisfied.²⁹⁶ This criticism also fails to recognise that the West Moreton board was not responsible for developing the new Statewide continuum of services. That was a matter for the CHQHHS board to monitor. Instead, the WMHSS board was, after May 2013, concerned to ensure that the current and waitlisted patients of the BAC were transitioned to appropriate care options. From the outset it was recognised that this would occur prior to the full implementation of the new services, and would rely upon individually-developed wrap around services (as acknowledged in the ECRG report) for each of the patients.²⁹⁷
- 6.24 The criticism that the board should have been told precisely what services were being (and were to be) provided to each patient before it could be satisfied that its condition on closure had been satisfied²⁹⁸ is not valid. The board did not possess the relevant clinical expertise. It was in no position to assess whether the package of service for each patient was appropriate. That is not part of the role of a board. That was a matter for the clinicians. But what the board needed to be assured of, was that prior to closure of the BAC each transitioning patient received appropriate alternative care. This assurance was given to the board of WMHSS.²⁹⁹ As will appear, assurances were also given to the Minister.

²⁹¹ The same comments apply analogously to senior members of the Health Department, such as Deputy Directors General and Directors General, and the Minister. Refer to Dr O'Connell's evidence at [T12-13:15 – T12:14:47](#).

²⁹² Section 189 relevantly provides:

If:

(a) *a director relies on information, professional or expert advice, given or prepared by:*
 (i) *an employee of the corporation whom the director believes on reasonable grounds to be reliable and competent in relation to the matters concerned;*

...

(b) *the reliance was made:*
 (i) *in good faith; and*
 (ii) *after making an independent assessment of the information or advice, having regard to the director's knowledge of the corporation and the complexity of the structure and operations of the corporation; ...*

...

the director's reliance on the information or advice is taken to be reasonable unless the contrary is proved.

²⁹³ T9-57:15-40.

²⁹⁴ For example, Counsel Assisting submissions at 209.

²⁹⁵ Counsel Assisting submissions at 220 to 222.

²⁹⁶ Counsel Assisting submissions at 223 and 232.

²⁹⁷ Statement of M Corbett (EXH.00041), MC-19; WMB.1000.0001.00049 (WMB.9000.0001.00145) at .00051.

²⁹⁸ Counsel Assisting submissions at 223.

²⁹⁹ T9-38:6-11.

7 Closure date

Date

- 7.1 The BAC formally closed on 31 January 2014, following the transition of the last patient from the service on 24 January 2014.³⁰⁰

Flexibility around closure date

- 7.2 The evidence is equivocal that the closure date of the BAC was flexible, and remained flexible until all BAC patients had been safely and effectively transitioned.³⁰¹ BAC was to stay open for as long as it was required to be.
- 7.3 While there was flexibility in the closure date, it was acknowledged that the smaller the number of adolescents present in the facility the less 'flexible' the closure date became. This was due to clinical reasons: there were safety concerns associated with having a small number of adolescents in an empty ward on their own.³⁰²
- 7.4 Mr Springborg's evidence was that the closure date of BAC was always flexible. His communicated position was that BAC should not close unless appropriate arrangements had been made, to ensure there was no gap in services.³⁰³ This evidence was not contradicted, and was consistent with the evidence of all key decision-makers including Dr Corbett and Ms Dwyer.
- 7.5 Mr Springborg's view on the need for flexibility was communicated to all relevant stakeholders, including WMHHS (via Dr Corbett and Ms Dwyer),³⁰⁴ and the Directors-General of Health (Dr O'Connell,³⁰⁵ and Mr Maynard³⁰⁶).
- 7.6 All key decision-makers gave oral evidence of having been directly aware of the Minister's position on flexibility: including Dr Corbett,³⁰⁷ Dr O'Connell,³⁰⁸ and Mr Maynard.³⁰⁹ If they were not aware of it from the Minister himself, they nonetheless held a view consistent with that of the Minister. For example, Ms Dwyer gives evidence that she understood the West Moreton Board's position to be that BAC would not close for as long as it was required to be open to provide services to patients.³¹⁰

The Commissioner should find that:

1. The precise date of closure of BAC was flexible and was to be conditional on the safe and effective transitioning of BAC patients.
2. Mr Springborg's view was that the closure date of the BAC should be flexible and conditional on the safe and effective transitioning of BAC patients.
3. Mr Springborg communicated his view to the Director-General and WMHHS.

³⁰⁰ Statement of Dr Corbett (EXH.00041), paragraph 18.8.

³⁰¹ See e.g. Statement of Dr Corbett (EXH.00041), paragraph 18.13; statement of J Krause (EXH.00072), paragraph 34; statement of Dr A Brennan (EXH.00028), paragraph 77.

³⁰² T11-39:20-25 (Kelly).

³⁰³ Statement of L Springborg (EXH.00120), paragraph 106.

³⁰⁴ T15-37 Line 10 (Springborg).

³⁰⁵ T12-35:40-45 (O'Connell).

³⁰⁶ T12-35:40-45 (O'Connell).

³⁰⁷ T9-58:42 (Corbett).

³⁰⁸ T12-35:40-45 (O'Connell).

³⁰⁹ T12-83:15-20 (Maynard).

³¹⁰ T12-123:10-24 (Dwyer); T10-29:42 (Geppert).

Advice provided to Mr Springborg about patient safety and closure

- 7.7 It is submitted that Mr Springborg retained a level of oversight over the final closure of the BAC that was appropriate to a Minister for Health in the context of Queensland's devolved health system. During and immediately after the transition period, his office requested and was provided with updates regarding the transition of BAC patients to appropriate new services, by way of briefing notes directed to him, or to the Director-General. These include the following:
- (a) the briefing note to the Minister (undated, but likely December 2013) providing an update on the transition process. The document notes the flexible closure date, and the steps taken to date;³¹¹
 - (b) the briefing note to the Director-General dated 24 January 2014, concerning the transition of patients to 'appropriate mental health care providers';³¹²
 - (c) the briefing note to the Minister dated 30 January 2014, which informed the Minister that all patients had been 'discharged to appropriate care options';³¹³ and
 - (d) the briefing note to the Minister signed 28 March 2014.³¹⁴ This document informed the Minister that all patients had been discharged to appropriate care options, and of the status of further mental health services being established.
- 7.8 Mr Springborg was never advised by either WMHHS, the Department or the Director-General in late 2013 or early 2014 that the closure of BAC should be deferred because WMHHS could not effect adequate care arrangements for the patients.
- 7.9 Mr Maynard was Director-General at the time patients were being transitioned. He gave evidence that no concerns about the transition being raised with him, and that he expected to have been told about difficulties if there were any.³¹⁵ He also took positive steps to gain an understanding of the transition process, including having conversations with Dr Cleary, Dr Kingswell, and Dr Stathis about the matter.³¹⁶ He said that, as no concerns were raised with him, he did not raise any concerns with the Minister.³¹⁷
- 7.10 Mr Maynard was given confidence by the briefing notes that he received concerning the transition, as well as from discussions he had with Dr Cleary and Dr Kingswell, that the expert clinicians managing the transition period of the patients were working effectively. He was confident that any concerns would be escalated to him. None were.³¹⁸
- 7.11 Mr Springborg was advised that, prior to closure, all BAC patients had been transferred to appropriate care options. He accepted that advice.
- 7.12 It is submitted that the evidence indicates that Mr Springborg took all of the steps it was appropriate for a Minister to take, to be satisfied that appropriate clinical arrangements were in place before the closure of the BAC in late January 2014.

³¹¹ QHD.006.005.1169 (EXH.00231).

³¹² LJS.900.001.0059 (EXH.00120).

³¹³ LJS.900.001.0058 (EXH.00120).

³¹⁴ Statement of Mr Springborg (EXH.00120), exhibit LJS-9.

³¹⁵ T12-78:1-16 (Maynard).

³¹⁶ T12-78:30-38 (Maynard).

³¹⁷ T12-83:45-48 (Maynard).

³¹⁸ T12-84:1-10 (Maynard).

The Commissioner should find that:

1. Mr Springborg retained a level of oversight around the final closure process that was appropriate given his role as Minister for Health.
2. Mr Springborg was periodically updated about the closure process, and the process for the transitioning of patients to alternative services, by the Director-General.
3. Mr Springborg was advised that, prior to closure, all patients who had been admitted to the BAC patients, had been discharged to appropriate care options. He accepted that advice and it was appropriate for him to do so.
4. None of the Health Department, WMHHS or CHQHHS raised with Mr Springborg any concerns about the closure process, or the process for transitioning patients to alternative services, that should have prompted Mr Springborg to seek to defer the closure of the BAC beyond January 2014.

8 The current state of the adolescent mental health strategy

Development of the new continuum of care (2013 onwards)

- 8.1 Once the West Moreton Board decided to approve the closure of BAC in May 2013 and the development of an implementation plan to support the proposed closure of BAC, CHQHHS took over responsibility for the implementation the strategy to provide new services.³¹⁹
- 8.2 This included the planning and implementation for new and expanded statewide service options for adolescents requiring extended treatment and rehabilitation (**AETR**).³²⁰
- 8.3 Dr Geppert explains the transition of responsibility from WMHHS to CHQHHS (which was responsible for the new Lady Cilento Hospital, including the new adolescent inpatient unit):³²¹
 - (a) on 23 May 2013, West Moreton Board approved the development of an implementation plan to support the proposed closure of BAC; and
 - (b) on 23 July 2013, Dr Geppert attended a meeting to discuss the implementation stage of the BAC strategy. At this meeting, it was decided that governance for the implementation was to shift from WMHHS and assumed by CHQHHS, via a Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy (**SWAETRI**) Steering Committee.
- 8.4 As noted earlier, responsibility for the statewide service was formally transferred from WMHHS to CHQHHS by the amendment of their respective Service Agreements.
- 8.5 CHQHHS' Steering Committee included clinical experts Dr Stathis, Dr Geppert, Ms Krause. The Steering Committee implemented the SWAETRI Project Plan. The Project Plan for the SWAETRI indicates that the role of the Steering Committee was to:
 - (a) develop service options within a statewide mental health model of service for adolescent extended treatment and rehabilitation, within a defined time line;

³¹⁹ Statement of Dr Geppert (EXH.00055), paragraph 3.7(g)(vi).

³²⁰ Statement of Dr Geppert (EXH.00055), paragraph 3.7(g)(vi).

³²¹ Statement of Dr Geppert (EXH.00055), paragraph 4.1 to 4.3.

- (b) develop an Implementation Plan to achieve the alternative model of service for adolescent mental health extended treatment and rehabilitation, within a defined time line; and
 - (c) consider in all decision-making the key principles and recommendations as defined through the ECRG and Planning Group of the Barrett Adolescent Strategy (including in relation to a Tier 3 service).³²²
- 8.6 The Steering Committee established several working groups, one of which (the Service Options Implementation Working Group) had the task of building on the ECRG recommendations and develop preferred service options for adolescent mental health extended treatment and rehabilitation.³²³
- 8.7 In November 2013 the Steering Committee invited families of BAC patients to make submissions in relation to the development of service options.³²⁴ Families gave a presentation to the Steering Committee on 4 November 2013.³²⁵
- 8.8 The matters set out above demonstrate that CHQHHS developed the new statewide AETR strategy in a manner that:
- (a) was considered and logical;
 - (b) was guided by clinical experts, and included the input of families of BAC patients; and
 - (c) considered, in all of its decision-making, the key principles and recommendations of the ECRG and Planning Group, including in relation to a "Tier 3" service.
- 8.9 Ultimately, a comprehensive suite of services was developed by the CHQHHS Steering Committee for a new state-wide AETR model of care. The services developed include:³²⁶
- (a) an extension of the Adolescent Day Program Services;
 - (b) the Assertive Mobile Youth Outreach Service (**AMYOS**);
 - (c) the Youth Residential Service for youth between the ages of 16-21;
 - (d) a Step-Up/Step Down facility; and
 - (e) state-wide sub-acute beds, which involve extended treatment inpatient beds with access to on-site schooling.
- 8.10 CHQHHS also developed models of care for each of these services.³²⁷

New services become available

- 8.11 The new services became available at different times. Dr Geppert described a '*staged process around service delivery*'.³²⁸

³²² Statement of Dr Stathis (EXH.00122), paragraph 15.

³²³ Statement of Dr Stathis (EXH.00122), paragraph 22, Exhibit N; DSS.001.001.363

³²⁴ Statement of Dr Stathis (EXH.00122), paragraph 18.

³²⁵ Statement of Dr Stathis (EXH.00122), paragraph 18, and Exhibit K to the statement.

³²⁶ Statement of Dr Stathis (EXH.00122), paragraph 58, and Exhibit X to the statement.

³²⁷ Statement of Dr Stathis (EXH.00122), Exhibit X.

³²⁸ T10-27 L33

- 8.12 This is not surprising given the significance of the shift in the model of care, and the infrastructure investment required in it (e.g. in Youth Residential and Step-Up/Step Down facilities) and the requirement to recruit and train new staff for the new AMYOS service.³²⁹
- 8.13 The services became available in the following way:
- (a) from the time the BAC closed, sub-acute beds were available at the Mater Hospital. Sub-acute beds were then provided at the Lady Cilento Children's Hospital from November 2014³³⁰;
 - (b) in March 2014, a Youth Residential facility opened in Greenslopes.³³¹ There is currently a Youth Residential facility in Cairns, and further facilities will be opened in Townsville in 2016;³³²
 - (c) recruitment for the AMYOS teams occurred in February to April 2014.³³³ AMYOS teams began operating in mid-to-late July 2014.³³⁴ There are currently 9 AMYOS teams in place across Queensland; and³³⁵
 - (d) the Step-Up/Step Down facility has not been built.³³⁶
- 8.14 As at today:
- (a) the recurrent costs of the full continuum of care was estimated to be \$22m in late 2015, but the current government has not approved that further funding;³³⁷ and
 - (b) in June 2015 the government decided to cease funding the LCCH beds.³³⁸

Election commitment of new government

- 8.15 There is evidence that an election commitment was made by the then Opposition, prior to the 2015 State election, which included the building of a new 22 bed extended inpatient facility for adolescents.³³⁹ The commitment was made in the context of a criticism of Mr Springborg for closing the BAC and not proceeding with the Redlands project, and, it is said, rejecting the recommendations of the ECRG Report to have a Tier 3 facility.³⁴⁰
- 8.16 The evidence is that work has been done to implement the election commitment, and that options being considered include building a new 22 bed facility, or three seven bed facilities. A Youth Mental Health [Election] Commitments Committee has been established.³⁴¹ A "policy document" has been produced, but it has been described in an internal email as "Cabinet in confidence"³⁴², and has not been seen by Dr Stathis.³⁴³ This apparently confidential policy document has not been placed before the Commission. Moreover, no evidence has been called

³²⁹ T24-73 L 5-15 (Dr Stathis)

³³⁰ CHS.500.0001.0001 (EXH.00278), page 7

³³¹ T10-29 L15 (Dr Geppert)

³³² CHS.500.0001.0001 (EXH.00278), page 7

³³³ T10-29 L23 (Dr Geppert)

³³⁴ Supplementary Statement of Dr Stathis, paragraph 69.

³³⁵ CHS.500.0001.0001 (EXH.00278), page 7

³³⁶ CHS.500.0001.0001 (EXH.00278), page 7

³³⁷ Evidence of Dr Cleary, at T14-48:20-35.

³³⁸ T24-78 L15-20 (Dr Stathis).

³³⁹ QHD.006.002.8924 (EXH.00253).

³⁴⁰ QHD.006.002.8924 (EXH.00253).

³⁴¹ QHD.004.006.3961 (EXH.00278).

³⁴² QHD.013.001.1080 (EXH.00277).

³⁴³ T24-64.

from the current Director-General, or from the Minister for Health, to explain what exactly is proposed to be done in connection with the government's election commitment, or otherwise in relation to building a new extended stay inpatient service.

- 8.17 There is, however, evidence that senior clinicians are concerned about the prospect of resources being committed to a new extended inpatient facility.
- 8.18 In about March 2015 Dr Daubney was tasked by Dr Stathis with developing a model of care for an extended stay inpatient unit, but reported that he could not find evidence to support a facility of that kind.³⁴⁴ Dr Stathis attests to discussions he had with a number of colleagues and 'everyone was struggling with determining whether the sub-acute beds were necessary and/or what type of model of care we would be able to provide.'³⁴⁵ In an email exchange of 17 March 2015 between Drs Stathis, Dr Daubney, Ms Adamson and Ms Krause,³⁴⁶ Dr Daubney said that:

'Inpatient treatment has been influenced internationally by managed care funding, an adoption of treating adolescents in the least restrictive environment and the concern that there is the risk of potential harm by an admission e.g. regression. This had lead [sic] to a significant decrease to average length of stay with the average being under five days (Carlisle 2012).'

- 8.19 In the same email, Ms Adamson stated that:³⁴⁷

'I just need to raise my escalating concern that there seems to be an absence of clinical justification in our briefing to the Minister and/or Premier regarding the election proposal for a "new Barrett"...

I wonder if this is something we should be escalating to Fionnagh to see if there is any way we can facilitate a conversation with the Minister and/or Premier's Office to discuss the clinical reasons why CHQ has adopted the AMHETI model of service, and how the current research and evidence does not support long term (> 12mths) inpatient admission for extended treatment; nor does the population support diversion of significant financial resources to Townsville when 74% of adolescents reside in SE Qld.'

- 8.20 Ms Krause went on in the email chain to describe the proposal to build a new 22 bed facility as a "fiasco".³⁴⁸ Dr Stathis candidly confirmed in his evidence that he was concerned by this plan,³⁴⁹ and that it would be irresponsible to commit to a model of service in the absence of evidence for it.³⁵⁰ Ms Adamson said that her concern was that the government had not consulted in relation to the proposal.³⁵¹

January 2016 CHQ discussion paper

- 8.21 The evidence is that thereafter, CHQ began to prepare a discussion paper that considered the evidence base and clinical considerations surrounding the development of a design specific extended stay adolescent inpatient unit. This resulted a document prepared within CHQ, styled the Statewide Sub-Acute Beds Discussion Paper dated January 2016 (**SSB Discussion**

³⁴⁴ T24-77:45-T24-78:6.

³⁴⁵ T24-68:25-35.

³⁴⁶ QHD.004.006.3930 (EXH.00291)

³⁴⁷ QHD.004.006.3930 (EXH.00291)

³⁴⁸ QHD.004.006.3930 (EXH.00291)

³⁴⁹ T24-65.

³⁵⁰ T24-78:10-15.

³⁵¹ T25-60:10-15.

Paper).³⁵² The document was the subject of evidence from Dr Stathis, who agreed with its contents.³⁵³

- 8.22 Significantly, whilst the evidence demonstrates that the decision to cease the Redlands facility was driven by clinical considerations originating within the Mental Health Branch (and discussed with the Chief Health Officer), a strikingly similar conclusion is effectively reached by different clinicians within CHQ, some four years later, as reflected in the SSB Discussion Paper. There is no doubt that had this discussion paper been available in May 2012, it would have provided significant additional support for the decision to discontinue the Redlands project.
- 8.23 The submissions of Counsel Assisting did not engage with the SSB Discussion Paper, or with the work of Dr Michael Daubney in March 2015 that preceded it. The SSB Discussion Paper made the following recommendations:³⁵⁴
- (a) most adolescents requiring extended inpatient care be stabilised in their nearest existing acute adolescent unit prior to discharge to less restrictive care;
 - (b) any proposed extended inpatient service be based on a clearly-articulated model of service with explicit attention to risks associated with extended inpatient admissions; and
 - (c) additional resources should be directed towards establishing a comprehensive continuum of community-based adolescent mental health services across Queensland.
- 8.24 The SSB Discussion Paper also makes the following other key points:
- (a) There is no evidence to support a conclusion that an extended inpatient admission will provide a positive outcome for most adolescents with mental health issues.³⁵⁵
 - (b) There is, in contrast, significant and growing evidence that adolescents with severe and complex mental health disorders are effectively treated in the community.³⁵⁶
 - (c) There are real risks associated with extended inpatient admissions, including:³⁵⁷
 - (i) dislocation from family, friends and school;
 - (ii) stigma associated with an admission;
 - (iii) contagion from extended contact with other mentally unwell young people; and
 - (iv) inability to cope in the community following discharge, associated with institutionalisation.

TOR 4: Whether the Commissioner should make clinical recommendations as to future service delivery for Queensland adolescents suffering from severe or complex mental health problems

- 8.25 The foregoing provide an important context for the final issue that these submissions address.

³⁵² CHS.500.0001.0001 (EXH.00278).

³⁵³ T24-75 to T24-85.

³⁵⁴ CHS.500.0001.0001 (EXH.00278), page 8

³⁵⁵ CHS.500.0001.0001 (EXH.00278), page 8

³⁵⁶ CHS.500.0001.0001 (EXH.00278), page 38

³⁵⁷ See further CHS.500.0001.0001 (EXH.00278), page 54-59

- 8.26 That issue is whether the Commissioner should seek to make recommendations as to future service delivery for Queensland adolescents suffering from severe or complex mental health needs; and in particular, whether the Commissioner should make recommendations about whether an extended treatment and rehabilitation inpatient service should, or should not, be provided in Queensland.
- 8.27 It is submitted that the Commissioner is not required to, and should not, make recommendations on these issues, for the following reasons.
- 8.28 *First*, as discussed in **Part 2** of these submissions, the question of whether or not a BAC-type facility should form part of adolescent extended treatment and rehabilitation services in Queensland does not fall within this Commission's terms of reference.
- 8.29 *Second*, related to this first point, the Commission has not been constituted to allow it readily to make such recommendations. The Commissioner has not been provided with the support of a Deputy Commissioner with expertise in adolescent mental health, or public health administration, to assist in (a) identifying what relevant evidence should be obtained and placed before the Commission, and (b) considering and resolving conflicts in the evidence, that would be relevant to this forward looking clinical question. It is submitted that clinical expertise of this kind is essential if the Commission is to be tasked with not only inquiring into and reporting upon what has in fact occurred, but is also to be given the heavy responsibility of advising government as to clinical matters going forward. Further, no independent expert has been briefed to provide a report to the Commission on this issue. The Commission is not in a position safely or properly to make a recommendation on this point.
- 8.30 *Third*, the evidence before the Commission does not allow proper consideration of the issue. Any such recommendation would require the Commission first to undertake the cost-benefit analysis discussed in **Part 3** of these submissions. The evidence does not permit such an analysis to occur. There is no considered evidence as to the form such a facility may take, its likely cost, and what other services may have to be reduced or deferred to fund such a new service.
- 8.31 *Fourth*, Counsel Assisting do not invite the Commissioner to make a recommendation of the kind now being considered.
- 8.32 *Finally*, if, contrary to these submissions, the Commission is minded to make recommendations on this issue, it is submitted that such recommendations should be as follows:
- (a) the matter should be considered by CHQ in consultation with MHAODB, in the light of the observations in the Commissioner's report;
 - (b) the matter should be governed by clinical advice in the light of available funding parameters, and should not be influenced by political considerations; and
 - (c) if the Commissioner considers that it is essential for the Report to make a finding on the issue, the Commissioner should recommend that a design specific inpatient facility not form part of the adolescent extended treatment and rehabilitation services to be provided in Queensland. This is because that the weight of expert evidence before the Commission is against such a facility, and in particular, the risks of harm to young people from extended inpatient admission cannot be justified in circumstances where there is no good evidence that extended inpatient admissions are therapeutically effective: see paragraphs 2.22 to 2.58 and 8.21 to 8.24 above.

DB O'Sullivan QC

J O'Regan

23 March 2016

Appendix A – Chronology

Date	Event	Source
1982	BAC opens day patient service	Statement of Breakey, paragraph 17
1983	BAC opens inpatient service	Statement of Breakey, paragraph 17
December 1986	Appointment of Dr Sadler to BAC	Statement of Dr Sadler, paragraph 13(d)
October 2008	Report of the site evaluation subgroup: Site Options Paper for the redevelopment of the Barrett Adolescent Centre	Statement of McDermott, BMCM-3; MSS.001.002.0229
January 2009	Minister Robertson approves the acquisition of the Redlands site.	QHD.004.014.8347
22.06.2009	Government Response to the 2008 Report of the Premier's Koala Taskforce	QHD.006.005.1554
29.09.2009	The Walker report into the BAC is delivered.	GRA.010.001.0001 at 1337
17.12.2009	Briefing note to Minister Lucas noting impact on Redlands project of the freeze on clearing government land (to protect koalas)	QHD.004.014.4244
February 2010	Briefing note to Minister Lucas noting expect construction at Redlands to start December 2010 and new facility commissioned Aug/Oct 2011.	QHD.007.001.1928
07.05.2010	Briefing note to Deputy DG noting BAC a \$4.8m funding shortfall for the Redlands project.	QHD.004.014.6973
22.10.2010	Briefing note to Minister Wilson noting that Redland project is \$2.8m over (an increased) budget, that construction expected to commence Oct 2012 with practical completion Oct 2013.	QHD.006.005.2722
July 2011	Estimates Brief records " <i>No funding in the 2011-12 State budget to progress implementation of the Plan due to fiscal pressure.</i> "	Dr Young statement, CHS.900.005.0001 at .0022
September 2011	Recognition that Governor-in-Council approval needed to increase the expenditure on the Stage 1 Capital Works program from \$121,209,000 (GST exclusive) to \$148,351,000 million (GST exclusive)	QHD.007.002.1462 at .1463, paragraph 15
February 2012	Briefing note seeking approval to progress Redlands project notwithstanding it is over-budget. The note expect construction commence Jan 2013 with practical completion Jan 2014. Approval to proceed while over budget is not given.	QHD.004.014.8371
24 March 2012	Queensland State election	
03.04.2012	Mr Springborg sworn in as Minister for Health.	Statement of L Springborg, paragraph 1

Date	Event	Source
16.05.2012	DG approves cessation of the Redlands project.	Statement of L Springborg, paragraph 36, exhibit LJS-2; LJS.900.001. 00001 at 0032
28.08.2012	Minister Springborg approves allocation of funds to 12 rural hospitals prioritised infrastructure needs.	Statement of L Springborg, paragraph 36, exhibit LJS-3; LJS.900.001. 00001 at 0036
25.10.2012	Sharon Kelly meets with MHAODB (including Kingswell and Geppert). At meeting discussed that BAC should close and that the BAC model not contemporary.	Statement of Kelly, paragraphs 9.2 to 9.8
08.11.2012	Dr McDermott gives evidence to the Queensland child protection inquiry and states that the BAC's director had been told the BAC would close around January 2013.	Statement of McDermott, paragraph 92
16.11.2012	Start date for WMHHS Project Plan	Statement Dr Stathis, Exhibit D; WMS.0012.0001.14639
21.11.2012	First meeting of the Planning Group	Statement of Kelly, paragraph 30.2
12.12.2012	WMHHS meeting with Minister Springborg	
08.05.2013	ECRG provides its report to WMHHS	Statement of Kelly, paragraph 27.2; QHD.005.001.4360 at 4637.
May 2013	Planning Group considers ECRG report and formulates its recommendations	Statement of Kelly, paragraph 11.17-11.18
24.05.2013	West Moreton board considers Planning Group's recommendations	
17.06.2013	Meeting Dwyer, Kelly and Geppert (WMHHS) with O'Connell (D-G) and Cleary (D D-G) regarding proposed closure of BAC and development of new services	Statement of Dwyer, paragraph 10.6 Statement of Kelly, paragraph 17.5 Statement of Cleary, paragraph 84(viii)
15.07.2013	Minister Springborg is briefed by WMHHS regarding proposed closure of BAC and development of new services.	Affidavit of Springborg, paragraph 54 Statement of M Corbett, paragraph 8.3
06.08.2013	WMHSS and CHQHHS media release re closure of BAC and transfer of responsibility for services from WMHHS to CHQHHS.	Affidavit of Springborg, LJS-7; LJS.900.001.0057
06.08.2013	Minister Springborg radio interviews in which he discusses that the BAC will close in early 2014.	Affidavit of Springborg, paragraph 62
10.09.2013	Dr Sadler [REDACTED]	Statement of Dr Sadler, paragraph 35

Date	Event	Source
30.01.2014	Minister's office receives briefing note advising all BAC patients "discharged to appropriate care options" as at 24 January 2014"	Affidavit of Springborg, LJS-8; (LJS.900.001.0001 at .0058).
31.01.2014	BAC closes.	
February 2014	Mater sub-acute beds available	CHS.500.0001.0001
March 2014	Youth residential facility at Greenslopes opens	T10-29:15 (Dr Geppert)
July 2014	AMYOS services begin operating	Supplementary Statement of Dr Stathis, paragraph 69
24.08.2014	ALP commits to opening a 22-bed facility (election promise 146)	QHD.006.002.8924
30.10.2014	Report ' <i>Transitional Care for Adolescent Patients of the Barrett Adolescent Centre</i> ', prepared by Associate Professor Beth Kotze and Ms Tania Skippen.	Statement of T Skippen, Exhibit I; TSK.900.001.0281 at .0284
31.01.2015	Queensland State Election	
13.03.2015	Email M Daubney to I Adamson, S Stathis, M Kelly, A Davis and J Krause regarding proposal to build a new BAC-like facility and noting ' <i>there is the risk of potential harm by an admission e.g. regression.</i> '	QHD.004.006.3930
19.03.2015-20.03.2015	Email chain between J Krause, I Adamson and S Stathis, regarding 'AMHETI Policy Sub', and proposal to build a new BAC-like facility	QHD.013.001.1080
June 2015	Decision to cease funding LCCH sub-acute beds	T24-78 L15-20 (Dr Stathis)
09.09.2015-10.09.2015	Email chain between J Krause and F Dougan, copied to S Stathis, I Adamson and S Nowlan, which notes ' <i>most of this evidence points to assertive community based care and does not support long-term institutional care.</i> '	QHD.004.006.3961
January 2016	Statewide Sub-Acute Beds Discussion Paper published by CHQ.	CHS.500.0001.0001

Appendix B – Legal framework

1. The *Mental Health Act 2000 (MH Act)* is primarily concerned with the situation where a mentally ill person is to be (or has been) detained or treated on an involuntary basis. Otherwise, there is no separate statutory framework for the delivery of mental health services in Queensland. There is simply a statutory framework for the delivery of health services. That is contained in the HHB Act.

Background to the HHB Act

2. The HHB Act was previously known as the *Health and Hospitals Network Act 2011 (HHN Act)*.
3. The HHN Act represented a fundamental shift in how health services would be delivered in Queensland, from a centralised to a decentralised model.

Amendments in mid-2012

4. In 2012, the HHN Act was amended and renamed as the '*Hospital and Health Boards Act 2011*'.³⁵⁸ The amendments further decentralised the delivery of health services in Queensland. The objects of the HHB Act include strengthening local decision-making and accountability, local consumer and community engagement, and local clinician engagement.
5. More specifically, the amendments replaced 'Hospital and Health Networks' with 'Hospital and Health Services', which were to be controlled by Hospital and Health Boards.³⁵⁹ A board was appointed to the WMHHS. That Board included, as its Chair, Dr Mary Corbett.³⁶⁰

Operation of the HHB Act

6. The HHB Act established a number of key actors within Queensland's health system.

Hospital and Health Services (Services)

7. There are 17 Services in Queensland. The Services are individually accountable for their performance,³⁶¹ and are required to report on their performance to the Director-General.³⁶² Each Service is required to provide those health services that are contained in the Service Agreement, which is a contract negotiated between the Service and the Director-General of Queensland Health.³⁶³
8. The Service responsible for the operation of BAC was the WMHHS.

Hospital and Health Boards (Boards)

9. Each of the Services is managed by a Board.³⁶⁴ Each Board also appoints a chief executive to manage the Service.³⁶⁵
10. Since 18 May 2012, the Chair of the WMHHS Board has been Dr Mary Corbett.³⁶⁶ Since 30 July 2012, the chief executive of WMHHS was Ms Lesley Dwyer.³⁶⁷

³⁵⁸ By the *Health and Hospital Network and Other Legislation Amendment Act 2012 (Qld)*.

³⁵⁹ Section 5, *Health and Hospital Network and Other Legislation Amendment Act 2012 (Qld)*.

³⁶⁰ Statement of M Corbett (EXH.00041), paragraph 4.1.

³⁶¹ Section 9(1), HHB Act.

³⁶² Section 9(2), HHB Act.

³⁶³ Sections 16(1), 19(1), HHB Act.

³⁶⁴ Sections 7(2), 22, HHB Act.

³⁶⁵ Section 33, HHB Act.

³⁶⁶ Statement of Dr Mary Corbett (EXH.00041), WMB.9000.0001.0001.

11. Prior to its closure, the BAC was a unit within the Park Centre for Mental Health (The Park), which is a service within WMHHS' mental health services.³⁶⁸ WMHHS was responsible (by virtue of s 19 HHB Act) for the delivery of services at BAC.
12. The responsibility of WMHHS for the delivery of services at BAC was reflected in the terms of the Services Agreement between WMHHS and Queensland Health.³⁶⁹

The Department of Health (Department)

13. The Department is responsible for the overall management of the public sector health system, through the chief executive.³⁷⁰ The chief executive of the Department is also known as the Director-General.
14. Mental Health, Alcohol and Other Drugs Branch (**MHAODB**) is an organ of the Department. It is responsible for providing system-wide clinical, policy and planning leadership to support the delivery of safe, quality, evidence-based clinical and non-clinical mental health and alcohol and other drug services.³⁷¹
15. MHAODB has an advisory role in respect of clinical and professional standards within mental health services State-wide. MHAODB plays a major role in managing budgets for capital works projects for mental health projects in Queensland and managing those on a State-wide basis.³⁷²

The Chief Health Officer

16. The Chief Health Officer is a role created by section 52 HHB Act.
17. The functions of the Chief Health Officer include providing high-level advice to the Director-General and the Minister on health issues, including policy and legislative matters associated with the health and safety of the Queensland public: section 53 HHB Act.
18. Since 2005, Dr Jeannette Young has been the Chief Health Officer.³⁷³

The Director-General

19. In the HHB Act, the Director-General is called the 'chief executive'.
20. The Director-General is responsible for the overall management of the public health system and is the 'system manager'.³⁷⁴ The 'system manager role' involves:
 - (d) Statewide planning;
 - (e) managing Statewide industrial relations;
 - (f) managing major capital works;
 - (g) monitoring Service performance;

³⁶⁷ Statement of Lesley Dwyer (EXH.00049), WMS.9000.0010.0001.

³⁶⁸ Statement of Dr Mary Corbett (EXH.00041), paragraph 6.6; WMB.9000.001.0001.

³⁶⁹ WMS.1007.0484.00021 (EXH.00228).

³⁷⁰ Section 8, HHB Act.

³⁷¹ Source: <https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/contact/default.asp>

³⁷² Statement of T Eltham (EXH.00050), paragraph 9.2.

³⁷³ Statement of Dr Young (EXH.00186), paragraph 6.

³⁷⁴ Section 8, HHB Act.

(h) issuing binding health service directives to the Services.³⁷⁵

21. The relationship between the Director-General and each Service is governed by a Service Agreement, which is negotiated between the Director-General and each Service.³⁷⁶ The Director-General is subject to the directions of the Minister in managing the department.³⁷⁷

The Minister for Health (Minister)

22. Consistent with a decentralised model, the Minister has few explicit powers under the HHB Act. The powers the Minister does have are largely supervisory in nature, for example:

- (a) If a Service and the Director-General cannot agree on a term of a Service Agreement, then the Minister may decide the term.³⁷⁸
- (b) The Minister effectively controls the makeup of the Boards, because he is responsible for making recommendations to the Governor about the membership.³⁷⁹ The Minister can also suspend Board members if misconduct occurs.³⁸⁰
- (c) The appointment of a chief executive of a Service is subject to the approval of the Minister.³⁸¹

23. The Minister can also give a Service a written direction about a matter relevant to the performance of its functions under the HHB Act, if the Minister is satisfied it is necessary to do so in the public interest.³⁸² The Service must comply with the direction.³⁸³

24. The Minister may not give a direction about the health services to be provided to a particular person.³⁸⁴

25. The Director-General is subject to the directions of the Minister in managing the department.³⁸⁵ However the Director-General is not subject to the direction of the Minister in making decisions about particular individuals.³⁸⁶

³⁷⁵ Section 8, HHB Act.

³⁷⁶ Section 8, HHB Act.

³⁷⁷ Section 44F, HHB Act.

³⁷⁸ Section 38, HHB Act.

³⁷⁹ Section 23, HHB Act.

³⁸⁰ Section 27, HHB Act.

³⁸¹ Section 33(2), HHB Act.

³⁸² Section 44, HHB Act.

³⁸³ Section 44(5), HHB Act.

³⁸⁴ Section 44(3), HHB Act.

³⁸⁵ Section 44F, HHB Act.

³⁸⁶ Section 44F(2), HHB Act.