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

SUBMISSIONS ON BEHALF OF STATE OF QUEENSLAND

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1. INTRODUCTION

1. Pursuant to the *Commission of Inquiry Act 1950* (Qld) and Commissions of Inquiry Order (No. 4) 2015, the Barrett Adolescent Centre Commission of Inquiry (**COI**) is to make full and careful inquiry in an open and independent manner. The terms of reference (**TOR**) for the COI are as follows:

> *3.(a) the decision to close the Barrett Adolescent Centre (**BAC**) announced on 6 August 2013 by the then Minister for Health, including with respect to the cessation of the on-site integrated education program (the **closure decision**);*
>
> *(b) the bases for the closure decision;*
>
> *(c) without limiting paragraphs (a) and (b) above – the information, material, advice, processes, considerations and recommendations that related to or informed the closure decision and the decision-making process related to the closure decision;*
>
> *(d) for BAC patients transitioned to alternative care arrangements in association with the closure or anticipated closure, whether before or after the closure announcement (**transition clients**):*
>
> *i. how care, support, service quality and safety risks were identified, assessed, planned for, managed and implemented before and after the closure (**transition arrangements**); and*
>
> *ii. the adequacy of the transition arrangements;*
>
> *(e) the adequacy of the care, support and services that were provided to transition clients and their families;*
>
> *(f) the adequacy of support to BAC staff in relation to the closure and transitioning arrangements for transition clients;*
>
> *(g) any alternative for the replacement of BAC that was considered, the bases for the alternative not having been adopted, and any other alternatives that ought to have been considered;*
>
> *(h) without limiting paragraphs (d)-(g) above – the information, material, advice, processes, considerations and recommendations that related to or informed the transition arrangements and other matters mentioned in paragraphs (d)-(g) above;*
>
> *(i) whether any contraventions of the Mental Health Act 2000 or other Acts, regulations or directives have occurred with regard to patient safety and confidentiality.*
>
> *4. The Commissioner may make any other recommendations arising out of the evidence, considerations or findings of the Inquiry in relation to the matters set out in paragraphs (a) to (i) above that the Commissioner considers appropriate, including for clinically appropriate models of care for intensive mental health services to young people with severe and complex mental illness.*

2. With respect to those terms of reference, these submissions focus on:

(a) the closure decision, and in particular:

(i) the decision-making process of government and the efficacy of the processes of government in relation to the closure decision (TOR 3(c));

(ii) the responsibility for the closure decision (TOR 3(a));

(iii) the bases for the closure decision (TOR 3(b)), including Redlands Adolescent Extended Treatment Unit as an alternative or replacement for the BAC (TOR 3(g)); and

(iv) the legalities of the decision;

(b) issues relevant to the Department of Education and Training, namely:

(i) the nature of the school;

(ii) the closure decision and the consequences for the school (TOR 3(a));

(iii) the education transition of the transition clients (TOR 3(d)(ii));

(iv) the adequacy of support for education staff (TOR 3(e)); and

(v) the future provision of education services to young people with severe and complex mental illness (TOR 4);

(c) with respect to transition arrangements for transition clients (TOR 3(d)):

(i) the responsibility of implementing the transition arrangements;

(ii) adequacy of transition arrangements;

(iii) the role of Children's Health Queensland Hospital and Health Service (**CHQ**);

(iv) the availability of subacute beds;

(v) the interaction between West Moreton Hospital and Health Service (**West Moreton HHS**) and CHQ with respect to transition and new services;

(vi) brokerage funding arrangements; and

(vii) the findings of the Kotze/Skippen report;

(d) alternatives for the replacement of BAC (TOR 3(g) and 4), including:

(i) the planned suite of services;

(ii) the need for a facility to replace the BAC;

(iii) potential gaps in the present planned suite of services, particularly with respect to:

(A) the alignment of adolescent and adult services;

(B) services available for dual diagnosis clients; and

(iv) further options being considered by the Youth Mental Health Commitments Committee.

3. In addition:

(a) **Annexure A** to these submissions is a schedule of the objections to evidence made on behalf of the State of Queensland;[1] and

(b) **Annexure B** to these submissions is a schedule of objections to Counsel Assisting's closing submissions. This schedule has been prepared because of the limited time available to respond to Counsel Assisting's lengthy submissions, which contain a number of serious allegations. Accordingly, in the short time provided, it has not been possible to comprehensively set out the references to evidence that demonstrates that particulars of Counsel Assisting's submissions are not open on the evidence. If the COI intends to

[1] A copy of these objections was forwarded to the COI on 15 March 2016 and have been supplemented to add objections to more recently received statements.

make findings in line with the submissions identified in Annexure B, it is submitted that the State should be given a further opportunity to respond.

2. THE CLOSURE DECISION

2.1 Preliminary - the decision making processes of Queensland government

2.1.1 Ministers

4. The *Constitution of Queensland 2001*, Chapter 3 recognises the constitutional existence of Cabinet and Ministers of State (Part 3) and the Executive Council (Part 4), but does not specify their functions or powers.

5. The functions and powers of the Cabinet and the Ministers therefore depend upon the Westminster conventions of responsible government, which among other things require that Ministers are collectively and individually responsible to the people through the Parliament for their administration of the government of the State.

6. The Cabinet is a purely political decision-making body. No legislation confers any decision-making power on it. Very little legislation even mentions it. The Cabinet Handbook, which regulates its procedures, has no legal status. Thus, for example, if a Minister decides a matter without first taking it to Cabinet, the potential sanctions are purely political.

7. Section 44 of the Constitution recognises that Ministers are not only collectively responsible to the Parliament for the administration of the government, but are also individually responsible to the Parliament for the administration of their respective portfolios. Again, that is not the source of any legal decision-making power. The potential sanction for any nonfeasance or misfeasance is purely political.

8. Those arrangements are subject to statutory modification. The only relevant modification in relation to the health portfolio as it concerns or concerned the BAC is section 44 of the *Hospital and Health Boards Act 2011* (**HHB Act**), which permits the Minister to give a Hospital and Health Service (**HHS**) 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.

2.1.2 Departments and chief executives

9. The State has the powers of an individual.[2] That means that among other things it can own land, deliver health services, enter into contracts and open and close facilities. In doing such things, it generally acts through departments and their chief executives.

10. Departments of the public service are declared under the *Public Services Act 2008*, Chapter 1, Part 2, Division 2. A department is required to have a chief executive[3] who for present purposes is the Director-General. A chief executive's responsibilities are imposed by section 98 of the HHB Act. Those responsibilities are in addition to the chief executive's responsibilities under another Act.[4] A chief executive is subject to the directions of the portfolio Minister (here, the Minister for Health).[5]

11. Beyond that, however, the HHB Act leaves a great deal in the administration of a department to the discretion and judgment of the Director-General, including the frequency and detail of briefings to the Minister. The working relationship between the two is obviously critical to the administration of a department. As the relationship between any individual pairing of Minister and Director-General evolves, a refined understanding of the Minister's expectations and requirements will become apparent. There are few, if any, legal rules about those requirements.

12. In the case of the health portfolio, those issues are affected by health-specific legislation.

2.1.3 Health portfolio 2008 to present

Pre 1 July 2012

13. At all relevant times, Queensland Health has been a public service department declared under the *Public Service Act 2008*, Chapter 1, Part 2, Division 2, sections 14 - 20.[6]

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[2] Section 51(1) of the *Constitution of Queensland*.
[3] Section 93(1) of the HHB Act.
[4] Section 98(2) of the HHB Act.
[5] Section 100(1) of the HHB Act.
[6] A department's precise composition at any time depends on the succession of departmental arrangements notices under those provisions. Each notice is effectively an amendment of the accumulated effect of all

14. A department must have a chief executive.[7] For Queensland Health, the chief executive is the Director-General from time to time. A chief executive has general responsibilities in relation to the department.[8] Those responsibilities are in addition to the chief executive's responsibilities under another Act.[9] The chief executive is subject to the directions of the portfolio Minister (here, the Minister for Health).[10]

15. In addition to those characteristics as a public service department, the repealed *Health Services Act 1991* gave Queensland Health some characteristics not shared with other departments. Section 7 gave the Director-General additional health-related functions. Section 23 conferred functions on Health Service District Chief Executive Officers (**CEOs**), subject to the Director-General. The Act did not divide responsibility between the Director-General and Health Service Districts CEO in a way that would give either of them exclusive responsibility for deciding such matters as the closure of the BAC.

16. Part 3C provided for the delivery of State-wide health services through a health service employee appointed as manager for the service who was subject to the Director-General.[11]

17. As is, correctly, summarised in the Discussion Paper Part 4A:

> *13. ... in summary, Queensland Health was one large organisation up until 1 July 2012. The DG, subject to the Minister, had overall responsibility for the management, administration and delivery of public sector health services in the State.*

Post 1 July 2012

18. A significant change occurred on 1 July 2012 with the repeal of the *Health Services Act 1991* and the commencement of the HHB Act. From that time, the public sector health system has been comprised of the Hospital and Health Services (**HHSs**) and the department.

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previous notices, but they are never reprinted in consolidated form. The relevant '*department*' with respect to health issues is Queensland Health.

[7] Section 93(1) of the HHB Act.

[8] Section 98 of the HHB Act.

[9] Section 98(2) of the HHB Act.

[10] Section 100(1) of the HHB Act.

[11] Section 28ZD of the *Health Services Act 1991*.

19. The HHB Act was intended to decentralise control of the public sector health system, albeit gradually, to the HHSs and to give Queensland Health a primarily '*system manager*' function involving, among other things, a purchaser-provider relationship with HHSs.

20. However, the overall management of the public sector health system is the responsibility of the department, through the chief executive.[12]

2.1.4 The process of briefing notes

21. Counsel Assisting questioned numerous witnesses who are, or have previously been, senior departmental officers regarding:

    (a) the source of information referred to in briefing notes;

    (b) the sufficiency of the information in briefing notes; and

    (c) the veracity of the information in the briefing notes and the process, if any, followed by either the drafter or the recipient of the briefing note to verify the veracity of the information contained in the briefing note.

22. It was suggested that, with respect to important decisions such as a decision to cease a capital program or close a facility, relevant Directors-General or Ministers should be provided with much more extensive reports.

23. Further, in Counsel Assisting's closing submissions, repeated criticisms are made of briefing notes and decision-making process of the government. For example:[13]

    (a) at paragraph 184 of Counsel Assisting's closing submissions it is submitted that:

        > *The briefing note is remarkable not for its content but for the lack of supporting reports or information.*

    (b) at paragraph 268 of Counsel Assisting's closing submissions it is submitted that:

        > *The decision making was fragmented and involved:*

[12] Section 8(2) of the HHB Act.
[13] See also para 11, 120, 185, 188, 196, 203, 204, 205, 245, 249, 250 and 251 of Counsel Assisting's closing submissions.

(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.*

24. When considering this issue, it is important to understand the nature of the briefing process, and the reasons for the process, as it exists.

25. The briefing process is not limited to briefing notes alone. It is often supplemented by telephone conversations, face-to-face meetings and discussion about the topic at executive meetings.[14] This, and the purpose of briefing notes, was well explained by Dr O'Connell:[15]

> *And the mechanism for reporting to you is by the briefing note. Is that right?---Yes. And clearly it can be* ***supplemented with telephone conversations, face to face meetings and the discussion of the topic at executive meetings*** *but the Commission would have noticed that nearly all of the briefs which have been tabled have about six signatories to them. So it's* ***generated by a fairly low-level officer but then it's checked by various officers who add a level of experience and expertise to the decision before it's then finally presented to the Director-General for approval****. And then – and then the* ***Director-General also has knowledge*** *which perhaps even the officers below aren't aware of* ***because the Director-General is doing things like attending Cabinet budget review committee meetings, having separate meetings with the Minister and the Premier and – and Treasury officials. So there are other considerations which the Director-General can take into account in either agreeing to or vetoing a – a proposal for approval****.*
>
> *You see, I'm asking specifically not so much about policy areas, but about facts. If there was, say, a problem with flooding or koalas, don't you at least get somebody to go there and do a report or some sort of fact-checking?---No, because* ***the problem with koalas would only appear on a document like this because it had already been examined. The alternative that you're implying is that someone's inventing a problem with koalas.***
>
> *Or overstating?---****Or overstating, yes. To what end though? The people who would be recommending these actions to me would be highly reputable people.*** *You know, the two most relevant in this decision would have been a deputy director-general who's also the chief health officer, who had responsibility for the mental health branch at the time, and John Glaister, who's a senior – who was at the time a senior - - -*
>
> *So - - -?--- - - - officer, previously director-general of a smaller department.*
>
> *But isn't the point that what you're saying there is that there's a trust that you have that the level below you had done their job properly. But you know, don't*

[14] See, for example, Cleary T14-5/L27-34.

[15] T12-13/L35 - T12-14/L47 (emphasis added). See also O'Çonnell T12-10/L35 and T12-13/L25-30. Maynard T12-84/L1-5 and T12-87/L15-19. Springborg T15-6/L10-11, T15-6/L32-47 and T15-16/L43 to T15-17/L6.

> *you, that they're not the ones that are – that the deputy director-general isn't ascertaining the facts, is he?---**There has to be a level of trust throughout the organisation. It's a massive organisation. It's got 182 hospitals. At the time, it had 85,000 employees, and we're spending $12 billion a year. You know, it's larger than any of Australia's listed companies in terms of employees alone.***
>
> *Yes?---So **it's massive, and there has to be a sense of cascading down of both responsibility and accountability to officers below, and – and that's why the appointment of senior officers in a government department are such important appointments, because they have to be people who are able to prioritise, to balance, to assess situations and to be suspicious about decisions that are being asked of them.***
>
> *You see, the other problem – the opposite way to look at it, Dr O'Connell – and we're really dealing with a decision-making process here – is that if you get a report from a junior officer that goes up the line through several steps to the deputy director-general, and then you to by these briefing notes, isn't the danger of Chinese whispers?---Yes, of course there's that danger, and, you know, it's possible that – that mistakes have been made at each level in the decision-making by each of the officers at each of the levels. But the more levels there are, the more secure the process is overall, but, possibly also, the more delayed the process is in – in acting.*

26. Dr Young also explained that a briefing note often represents the production of a formal record about a strategic issue that has been the subject of consultation over an extended period of time.[16] The consultation included, in part, regular executive meetings.[17] For example, until July 2012 when there was a change in structure of Queensland Health, Dr Young had regular fortnightly meetings with Dr Kingswell at which they discussed ideas raised with Dr Young by the Director-General or her ideas on progression of mental health services; and Dr Kingswell would provide information about issues in his portfolio that he wanted to progress.[18]

27. A similar explanation of the process was provided by the Honourable Mr Springborg, who referred to the fact that you '*assimilate and accumulate information based on the sources and the advice that you receive*', including through the process of formal and informal meetings.[19] This process of information gathering is also apparent from the evidence of Dr O'Connell who, in responding to questions from Mr Freeburn QC, identified that information known to him when making the decision not to proceed with the Redlands project

[16] Exhibit 186 Affidavit of Dr Jeannette Young para 32; Young T21-96/L5-12.
[17] Exhibit 186 Affidavit of Dr Jeannette Young para 38.
[18] Young T21-67/L1-21.
[19] T15-26/L46 – T15-27/L12.

included information he had obtained from other sources such as cabinet-in-confidence briefing notes.[20]

28. In addition, information summarised in briefing notes may be sourced from other documents that are available to the author of the briefing note, or the person who verifies its contents.[21]

29. It is accepted that the briefing process involves senior departmental officers placing trust and confidence in their colleagues, and relies on the relevant expertise of the officers providing the briefing.

30. This, however, does not mean that a senior departmental officer, such as a Director-General, puts blind faith in every word of every briefing note placed before them. A senior departmental officer can question statements made in the briefing note that are not clear or which are a cause of concern for the officer.

31. This is evident from the testimony of Dr Cleary, who sent a briefing note back to Dr Kingswell, the Executive Director of the Mental Health, Alcohol and Other Drugs Branch (**MHAODB**), with a comment that the closure of the BAC should be led by West Moreton HHS.[22]

32. In addition, as was confirmed by the Honourable Mr Springborg, if a Minister disagrees with a decision of a Director-General, the Minister retains the right to veto such a decision.[23]

33. In light of the evidence referred to above, and having regard to the questions asked (and not asked) by Counsel Assisting of relevant senior departmental officers and the Honourable Mr Springborg, it is submitted that the criticisms made by Counsel Assisting are not justified, nor is it open for the Commissioner to conclude that the

[20] T12-12/L45-46.
[21] As much is evident from the evidence of Dr Young who, when questioned by Mr Freeburn QC about the absence of supporting reports or documents, was confident that there would have been supporting documents: she simply no longer had access to them T21-69/L32-43. No adverse conclusion could reasonably be drawn from the failure by Dr Young to attempt to source relevant documents given she could not easily ascertain what may or may not be required - T21-67/L27-38. Dr Young was also was given a very limited period (only 7 business days) within which to respond to the Requirement issued by the COI (see CHS.900.005.0001 at .0013 - .0014), in circumstances where her role as Chief Health Officer requires her to also address significant issues for Queensland, such as the Zika virus outbreak – T21-96/L1-8 and L31-39. Unlike some other witnesses, no further notice was issued to Dr Young by the COI to follow up on any outstanding issues that were regarded by the COI as requiring further explanation or documentation.
[22] Cleary T14-19/L30-45 and also Exhibit 40 Affidavit of Dr Michael Cleary para 84.
[23] Springborg T15-41/L1-10.

closure decision was made without a proper factual foundation or in the absence of expert advice.[24]

2.2 The closure decision

34. Pursuant to paragraph 3(a) of the terms of reference for the COI, the Commissioner is to investigate:

> *3.(a) the decision to close the Barrett Adolescent Centre (**BAC**) announced on 6 August 2013 by the then Minister for Health, including with respect to the cessation of the on-site integrated education program (the **closure decision**);*
>
> *(b) the bases for the closure decision;*
>
> *(c) without limiting paragraphs (a) and (b) above – the information, material, advice, processes, considerations and recommendations that related to or informed the closure decision and the decision-making process related to the closure decision;*

35. In particular, the Commissioner has requested submissions with respect to:

(a) Who purported to make the closure decision, and when?

(b) Who had the legal authority to make the closure decision?[25]

2.3 The bases for the closure decision

36. The questions posed by the Commissioner are premised on an assumption that it is possible to identify a single action or defining moment in time that constitutes the closure decision and that, therefore, it is possible to definitively identify:

(a) who purported to make the closure decision and when; and

(b) who had the legal authority to make the closure decision.

2.3.1 A continuum of decisions

37. As is demonstrated by the evidence before the COI, with respect to the closure of the BAC, the decision-making process was multifarious. No one entity had the responsibility to make the closure decision. It was a continuum of decisions by a number of entities, with each decision along the continuum affirming in principle the direction that the matter was heading, being towards the ultimate closure of the

[24] An indication of the factual foundation and expert advice on which decisions were based is outlined in section 2.3.
[25] T21-113/L1-5.

BAC. This is apparent when one considers a chronology of key events, particularly those events between October 2012 and August 2014. **Annexure C** to these submissions contains such a chronology.

38. By 6 August 2013, when the Minister announced the intention to close, there had been a '*meeting of the minds*' about the appropriateness of that course of action. It was a course of action that:

(a) had been endorsed by the West Moreton Hospital and Health Board (**HHB**);[26]

(b) was supported by the Health Service Chief Executive of the West Moreton HHS (Ms Dwyer),[27] the Executive Director of the West Moreton HHS (Ms Kelly)[28] and the Chair of the West Moreton Hospital and Health Board (Dr Corbett)[29];

(c) was supported by the Executive Director of the MHAODB (Dr Kingswell);[30] and

(d) was known to the then Minister for Health (the Honourable Mr Springborg),[31] who elected to announce the decision[32] rather than issue a directive staying the proposed course of action.

39. Further, while there were some differences between the various parties as to the bases for determining that the proposed course of action was appropriate, there was, nevertheless, notable factors in common, namely:

(a) the BAC was not a contemporary model of care;[33]

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[26] Exhibit 41 Statement of Dr Mary Corbett [WMB.9000.0001.0001] at [.00173] – [.00174].
[27] Exhibit 49 Statement of Lesley Dwyer para 11.4; Exhibit 41 Statement of Dr Mary Corbett at para 8.3(a).
[28] Exhibit 66 Statement of Sharon Kelly para 11.11; Exhibit 41 Statement of Dr Mary Corbett at para 8.3(a).
[29] Exhibit 41 Statement of Dr Mary Corbett at para 8.3(a).
[30] Exhibit 68 Statutory Declaration of Dr William Kingswell para 20(v). The Mental Health, Alcohol and Other Drugs Branch was responsible for providing expert clinical and policy advice to Queensland Health and HHSs – Exhibit 40 Statement of Michael Cleary para 61 and Exhibit 94 Affidavit of Dr Anthony O'Connell para 30(c).
[31] Exhibit 120 Affidavit of the Honourable Mr Lawrence Springborg para 60 and 81.
[32] Exhibit 120 Affidavit of the Honourable Mr Lawrence Springborg Exhibit LJS-7 LJS.900.001.0001 at .0057.
[33] Exhibit 50 Statutory Declaration of Timothy Eltham para 18.3(c); Exhibit 41 Statutory Declaration of Dr Mary Corbett para 17.5 and 17.11(c); Exhibit 49 Statutory Declaration of Lesley Dwyer para 11.4(a) and 11.6(c)-(d); Corbett T9-62/L25-45; Exhibit 66 Statutory Declaration of Sharon Kelly para 11.11(c); Exhibit 68 Statutory Declaration of Dr William Kingswell para 20(v); O'Connell T12-23/L19-21; Exhibit 120

(b) the risks and undesirability of having vulnerable adolescents in close proximity to adult forensic patients.[34] As was noted by Dr Kingswell:[35]

> *The EFTRU is a very different model of service. It's like a community care unit for mentally ill offenders. It's open. They can walk out. It has a gate. The likelihood of some harm coming to an adolescent on that site might not have been high and perhaps the immediacy wasn't urgent either, 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 asking a – 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?*

(c) the buildings were no longer considered suitable for the service provision in that the facility was aging and no longer safe for patients and staff;[36] and

(d) alternative service options were to be developed so that the BAC would not close until alternative arrangements for the BAC cohort that were deemed clinically appropriate were in place.[37]

2.3.2 Cessation of the Redlands project

40. It is also apparent from the evidence before the COI that the decision to close the BAC was not coincident with the decision to approve cessation of the Redlands project.[38] To the contrary, at the time the decision was made to cease the Redlands

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Affidavit of the Honourable Mr Lawrence Springborg para 77(c); Exhibit 40 Affidavit of Dr Michael Cleary para 80(iii) and 82; Cleary T14-22/L40-45.

[34] Exhibit 50 Statutory Declaration of Timothy Eltham para 18.3(a); Exhibit 41 Statutory Declaration of Dr Mary Corbett para 17.11(a); Exhibit 49 Statutory Declaration of Lesley Dwyer para 11.4(b) and 11.6(a); Exhibit 66 Statutory Declaration of Sharon Kelly para 11.11(b); Exhibit 68 Statutory Declaration of Dr William Kingswell para 20(v); O'Connell T12-23/L14-19; Exhibit 120 Affidavit of the Honourable Mr Lawrence Springborg para 77(b); Exhibit [to be tendered] Supplementary Affidavit of the Honourable Mr Lawrence Springborg LJS.900.002.0001 para 9 and 10; Exhibit 40 Affidavit of Dr Michael Cleary para 80(ii); Cleary T14-30/L39 – T14-31/L29.

[35] T13-20/L6-14.

[36] Exhibit 50 Statutory Declaration of Timothy Eltham para 14.1(c) and 18.3(b); Exhibit 41 Statutory Declaration of Dr Mary Corbett para 17.11(b); Exhibit 66 Statutory Declaration of Sharon Kelly para 11.11(a); Exhibit 68 Statutory Declaration of Dr William Kingswell para 20(v); Exhibit 40 Affidavit of Dr Michael Cleary para 80(i); Exhibit 120 Affidavit of the Honourable Mr Lawrence Springborg para 77(a).

[37] Exhibit 41 Statutory Declaration of Dr Mary Corbett para 11.2(c), 17.5 and 17.12; Exhibit 49 Statutory Declaration of Lesley Dwyer para 11.4(d)-(f); Exhibit 66 Statutory Declaration of Sharon Kelly para 11.11(d)-(e); Exhibit 120 Affidavit of the Honourable Mr Lawrence Springborg para 56 - 60; Springborg T15-17/L15-20

[38] Exhibit 186 Affidavit of Dr Jeannette Young para 36; Young T21-71/L29 – T21-73/L42 and T21-77/L18-42; Exhibit 40 Statement of Dr Michael Cleary para 27, 28, 38, 39; Cleary T14-5/L30 – T14-6/L13; Exhibit 94 Affidavit of Dr Anthony O'Connell para 11(f) and 13; O'Connell T12-19/L16-29; Kingswell T13-18/L12-17.

project, there had been no decision about the future of the BAC.[39] This is evident even from the Briefing Note of 3 May 2012 itself, which records:[40]

> *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. Limited sector consultation supports this review.*

41. There would be no need for '*a review of the existing adolescent centre at The Park*' if the decision to cease the Redlands project coincided with a decision to close the BAC.

42. As was explained by Dr Young, in the lead up to preparing the 3 May 2012 briefing note, Dr Kingswell had identified that the potential consequences of the proposal to cease the Redlands Adolescent Extended Treatment Unit would be:

    (a) the facility would need to be maintained at The Park, which was not considered a sensible option given the age of the facility;

    (b) a new facility at another location would need to be considered; or

    (c) a new model of care would need to be developed that involved enhancing multiple facilities throughout the State.[41]

43. These are the three options that Dr Young saw as open at the time.[42]

44. In terms of the third of these options, around May 2012 new mental health facilities were being built throughout the State and it was an option to enhance those facilities to make them suitable for adolescent care.[43]

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[39] Exhibit 186 Affidavit of Dr Jeannette Young para 39. See also Exhibit 50 Statement of Tim Eltham para 14.1 and 15.1; Exhibit 40 Statement of Dr Michael Cleary para 39; Cleary T14-5/L30 – T14-6/L13; Exhibit 94 Affidavit of Dr Anthony O'Connell para 13.
[40] Exhibit 186 Affidavit of Dr Jeannette Young Exhibit A p 11 (also DBK.001.001.0032 para 7).
[41] Exhibit 186 Affidavit of Dr Jeannette Young para 36; Young T21-72/L1-14 and L29-36.
[42] Young T21-77/L10-27.
[43] Exhibit 186 Affidavit of Dr Jeannette Young para 37 and 42 - 43; Young T21-72/L38-44 and T21-74/L13-20.

45. Given there had been no decision about the future of the BAC at the time the decision was made to cease the Redlands project:

(a) it is unremarkable that the briefing note with respect to cessation of the Redlands project did not attach written evidence of child and adolescent psychiatric advice; and

(b) the reasons for ceasing the Redlands project are of peripheral, if any, relevance.

46. Having said that, for completeness, with respect to the decision to cease the Redlands project, it should be noted that:

(a) around the time of the decision there was a whole of government budget strategy, which required Queensland Health to look in various areas for savings;[44]

(b) prior to verifying the 3 May 2012 briefing note, Dr Young:

(i) was generally aware that delivery of the project had been continuously delayed due to issues associated with site options analysis, meeting Koala Conservation Regulations requirements, securing suitable sites, resolving local community and elected representatives concerns; and that incorporating two projects into other site redevelopment projects had contributed to delays to the building program;[45]

(ii) was aware that other issues that delayed the delivery of the project included the extended timeframe taken to develop appropriate models of care and appropriate scopes of work prior to the standard architectural design process commencing; and that this was an issue because until you knew the model of care for the Redlands project, it was difficult to work out precisely what to build;[46]

[44] Young T21-71/L6-11.
[45] Young T21-85/L6-7; Exhibit 265 para 20.
[46] Young T21-85/L27-47; Exhibit 265 at QHD.007.002.1469.

(iii) was aware that, in January 2009, an external review of the BAC was commissioned and that it was to review the progress, appropriateness and models of care for the BAC;[47]

(iv) was cognisant that she had received advice that the model of care proposed at Redlands was out-dated and that current practice was to provide services in the community close to where patients ordinarily reside;[48]

(v) had accepted the (unsurprising) advice that the model of care proposed at Redlands, being a single facility to serve the entire State, was out-dated;[49] and

(vi) understood that the proposal to cancel the Redlands project was a significant matter and had satisfied herself that is was appropriate to request the Director-General to make that decision;[50]

(c) prior to the decision, in the months leading up to the briefing note, there had been 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;[51]

(d) there had been expert advice and clinical input into the decision, in particular there had been consistent advice from Dr Kingswell and Dr Gilhotra (the then Chief Psychiatrist) that contemporary practice, as reflected in the then draft National Mental Health Planning Framework, was moving away from extended inpatient facilities towards community-based care;[52]

[47] Young T21-81/L7-19; Exhibit 220.
[48] Young T21-82/L13-22.
[49] Young T21-82/L27-36.
[50] Young T21-82/L38-45.
[51] Exhibit 186 Affidavit of Dr Jeannette Young para 21; Young T21-70/L1 – T21-71/L4 and T21-83/L1-8.
[52] See, for example, Cleary T14-8/L17 – T14-9/L42; Young T21-74/L22-23; T21-98/L7-29.

(e) the *Queensland Plan for Mental Health 2007 – 2017*, which underpinned the capital works decision to pursue the Redlands project, was irrelevant by early 2012 (as was explained in considerable detail by Dr Kingswell);[53]

(f) Dr O'Connell gave evidence that factors causing the cessation of the Redlands project included extended land acquisition timeframes, delay in confirming the model of service delivery, challenges with the low-lying site at a time of sensitivity to health facilities being flood prone, budgetary constraints, issues with the community infrastructure designation process and emerging clinical preference to care for patients in a more community based (i.e. closer to home) model of care rather than an institution model;[54] and

(g) the delays with the project were, in part, a product of difficulties resolving environmental issues on the site[55] and, while such matters were not canvassed in the 3 May 2012 briefing note, they would have been known to the Director-General of Health as a consequence of briefings from the Health Infrastructure Branch.[56]

47. Subsequently, on 17 August 2012, Dr Young, as Acting Director-General of Health, approved a planned strategy for the targeted rectification of prioritised infrastructure issues and subsequent planning for 12 rural hospitals. This decision is the subject of a briefing note dated 17 August 2012.[57]

48. The decision to fund the 12 priority capital projects in regional and rural Queensland for hospital repairs:

(a) was made after the decision on 3 May 2012 to cease the Redlands project;

(b) involved use of funds previously allocated to the Redlands project;[58]

(c) was made before the decision to close the BAC;[59] and

[53] T13-18/L28 – T13-19/L29.
[54] Exhibit 94 para 10; T12-9/L19 – T12-13/L34.
[55] Exhibit 94 Affidavit of Dr Anthony O'Connell para 10 and 11; O'Connell T12-12/L41-46; Exhibit 227; Exhibit 265; Exhibit 237; Exhibit 266 at QHD.007.002.1444; Exhibit 40 Statement of Dr Michael Cleary para 28; Cleary T14-6/L15-31.
[56] See, for example, Exhibit 265 and Exhibit 266. Young T21-88/L5-26.
[57] QHD.006.005.2343.
[58] QHD.006.005.2343 at .2344.

(d) is unrelated to the decision to close the BAC.

2.3.3 Factual foundation and expert advice

49. It is clear from the evidence referred to above that there was a factual foundation for, and expert advice supporting, the closure decision, and earlier decisions about the cessation of the Redlands project and the allocation of funds to rural hospitals.

50. Having regard to the evidence referred to above, Counsel Assisting's submissions in paragraphs 120, 184, 185, 188, 196, 203, 204, 205, 210, 249, 250, 251, 268 and 269 should be rejected.

2.4 The legalities of the decision

51. To understand the processes required to be followed to document the agreed course of action to close the BAC, to ensure that it was effective, it is necessary to appreciate the relationship, as defined by legislation, between:

(a) HHSs;

(b) Hospital and Health Boards (**HHBs**);

(c) the Director-General of Queensland Health; and

(d) the Minister of Health.

2.4.1 The relationship between HHS, HHB, the Director-General of Queensland Health and the Minister for Health

52. The primary legislation is the HHB Act.

53. From 1 July 2012, the public sector health system has been comprised of the HHS and the department.

54. The relationship between the Director-General and the HHSs is a purchaser-provider relationship, governed by a service agreement between the Director-General and each HHS.

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[59] Young T21-73/L1-42.

55. Relevantly, under the HHB Act:

(a) a HHS has:

(i) a legal personality and represents the State;[60]

(ii) the powers of an individual subject to limitations;[61]

(iii) as its main function '*to deliver the hospital services, other health services, teaching, research and other services stated in the service agreement for the Service*';[62] and

(iv) the specific functions listed in section 19(2), including to enter into a service agreement with the Director-General;[63]

(b) a HHB controls the HHS for which it is established;[64]

(c) the chief executive, being the Director-General of Queensland Health, has:

(i) functions specified in section 45 that reflect the reallocation of responsibilities, particularly in relation to Queensland Health as system manager;

(ii) various powers, including the power to give a health service directive to a HHS under Part 3, Division 2; and

(d) although a Hospital and Health Service is not *generally* subject to direction by the Minister or Director-General of Queensland Health, a HHS is required to comply with:

(i) its obligations under a service agreement with the Director-General;[65]

(ii) ministerial directions in the public interest;[66]

[60] Section 18 of the HHB Act.
[61] Section 20 of the HHB Act.
[62] Section 19(1) of the HHB Act.
[63] Section 19(2)(b) of the HHB Act.
[64] Section 22 of the HHB Act.
[65] Part 2 Division 4 of the HHB Act.
[66] Section 44 of the HHB Act.

(iii) health service directives of the Director-General;[67] and

(iv) health employment directives of the Director-General.[68]

56. Under the HHB Act, the Director-General is subject to the Minister's directions, other than in relation to particular individuals.[69]

2.4.2 Service agreements

57. A '*service agreement*' is defined in section 16(1)(a) of the HHB Act to mean an agreement between the Director-General and a HHS about the '*health services*', among other things, to be provided by the HHS.

58. *'Health service*' is defined by s 15(1) of the HHB Act to mean '*a service for maintaining, improving, restoring or managing people's health and wellbeing*'.

59. On 28 June 2012, the 2012-13 Service Agreement between Queensland Health and West Moreton HHS was executed.[70] The 2012-13 Service Agreement:

(a) covered the period 1 July 2012 to 30 June 2013;[71]

(b) included clauses that confirmed that if either the Chief Executive (namely the Director-General of Queensland Health) or the HHS wanted to amend the terms of the service agreement:

(i) written notice must be provided of the proposed amendment; and

(ii) proposed amendments would only be negotiated and finalised during four stipulated amendment windows;[72]

(c) included a figure that depicted the process for negotiation and resolution of proposed amendments, which process included (if necessary) escalation to

[67] Section 47 of the HHB Act.
[68] Section 51A of the HHB Act.
[69] Section 44F of the HHB Act.
[70] Exhibit 228, 2012-13 West Moreton Service Agreement WMS.1007.0484.00021 at .00035. Executed by Dr O'Connell as Chief Executive – T12-32/L31-47.
[71] Exhibit 228 WMS.1007.0484.00021 at 00027.
[72] Exhibit 228, 2012-13 West Moreton Service Agreement WMS.1007.0484.00021 at .00027 - .00028.

the Director-General of Queensland Health and the Chair of the HHB and then to the Minister for Health;[73] and

(d) obliged West Moreton HHS to:

(i) comply with the terms of the service agreement;[74] and

(ii) meet all of the accountabilities in, *inter alia,* Schedule 2 Hospital and Health Service Profile,[75] which recorded that West Moreton HHS had oversight responsibility for State-wide '*adolescent unit services*' provided by the Park.[76]

60. Thus, for the period 1 July 2012 to 30 June 2013, West Moreton HHS had oversight responsibility for the BAC.

61. A further service agreement was executed on 20 June 2013,[77] covering the period 1 July 2013 to 30 June 2016.[78] The objectives of the agreement included specifications of '*the hospital services (with respect to outcomes and outputs), other health services, teaching, research and other services to be provided by the HHS*', as well as the funding to be provided to the HHS for the provision of the services.[79] This agreement also contained a process for amendments to be made within particular windows, and included a figure illustrating the process for negotiation and resolution of amendment proposals.[80]

62. By that agreement the services to be provided by West Moreton HHS included '*Adolescent Extended Treatment and Rehabilitation Centre (state-wide*)'.[81] This service was the BAC.[82]

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[73] Exhibit 228, 2012-13 West Moreton Service Agreement WMS.1007.0484.00021 at .00028.
[74] Exhibit 228, 2012-13 West Moreton Service Agreement WMS.1007.0484.00021 at .00031.
[75] Exhibit 228, 2012-13 West Moreton Service Agreement WMS.1007.0484.00021 at .00033.
[76] Exhibit 228, 2012-13 West Moreton Service Agreement WMS.1007.0484.00021 at .00041.
[77] Exhibit 182 West Moreton Hospital and Health Service - Service Agreement 2013/14-2015/16 executed by Dr O'Connell as Chief Executive and Mary Corbett as Chair WMHHS Board – LJS.002.0001.0014 at .0030.
[78] Exhibit 182 West Moreton Hospital and Health Service - Service Agreement 2013/14-2015/16 LJS.002.0001.0014 at .0019.
[79] Exhibit 182 West Moreton Hospital and Health Service - Service Agreement 2013/14-2015/16 LJS.002.0001.0014 at .0018.
[80] Exhibit 182 West Moreton Hospital and Health Service - Service Agreement 2013/14-2015/16 LJS.002.0001.0014 at .0020 to .0021.
[81] Exhibit 182 West Moreton Hospital and Health Service - Service Agreement 2013/14-2015/16 LJS.002.0001.0014 at .0039 and .0040.
[82] Corbett T9-68/L42 – T9-69/L10.

63. West Moreton Hospital and Health Service - Service Agreement 2013/14-2015/16 was amended by a Deed of Amendment July 2014. It was executed by Mr Maynard as Director-General of Queensland Health on 6 August 2014[83] and by Dr Corbett as Chair of the West Moreton HHB on 29 August 2014.[84] By the amended agreement, the responsibility for West Moreton HHS to oversight the delivery of State-wide Adolescent Extended Treatment and Rehabilitation Centre services was removed.[85]

64. On 30 January 2014, the service agreement with CHQ was also amended.[86] By that agreement, CHQ:

(a) had oversight responsibility of e-Child and Youth Mental Health Service (services to Cairns and Hinterland, Central West, Mackay, North West, and Townsville HHS);[87] and

(b) was to continue to host and deliver specified programs including the '*State-wide Adolescent Extended Treatment and Rehabilitation (AETR) Implementation Strategy*'.[88]

2.4.3 The power to make the decision to close

65. Having regard to the legislative framework outlined above, and the evidence above about the service agreements between West Moreton HHS and the Director-General of Queensland Health, the State submits that:

(a) prior to 1 July 2012, any decision to close the BAC was within the power of either the Minister or the Director-General of Queensland Health[89] in that,

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[83] Exhibit 183 West Moreton Hospital and Health Service - Service Agreement 2013/14-2015/16 Deed of Amendment July 2014 - LJS.002.0001.0062 at .0068.
[84] Exhibit 183 West Moreton Hospital and Health Service - Service Agreement 2013/14-2015/16 Deed of Amendment July 2014 - LJS.002.0001.0062 at .0069.
[85] Corbett T9-70/L30-40.
[86] Exhibit 245 Children's Health Queensland Hospital and Health Service 2013/14 – 2015/16 Service Agreement - Deed of Amendment January 2014 - LJS.002.0001.0001 at .0010.
[87] Exhibit 245 Children's Health Queensland Hospital and Health Service 2013/14 – 2015/16 Service Agreement - Deed of Amendment January 2014, clause 6.2.5 - LJS.002.0001.0001 at .0008.
[88] Exhibit 245 Children's Health Queensland Hospital and Health Service 2013/14 – 2015/16 Service Agreement - Deed of Amendment January 2014, clause 6.2.5 - LJS.002.0001.0001 at .0009. See also Cleary 14-43/L15-30.
[89] From time to time the name of the Department was changed from Queensland Health to the Department of Health. For ease of reference, these submissions simply refer to the relevant department as Queensland Health.

at that time, a State-wide service such as the BAC was funded and operated by Queensland Health on behalf of the State; and

(b) after 1 July 2012, any decision to close the BAC was within the power of those who had authority to amend the Service Agreement. The process for negotiating any amendments to the Service Agreement is as set out in the service agreement itself and involved:

(i) agreement of the Relationship Management Group;[90] or, if unresolved,

(ii) agreement between the Deputy Director-General and the West Moreton HHS Chief Executive; or, if unresolved,

(iii) agreement between the Director-General of Queensland Health (or delegate) and the Chair of the West Moreton HHB; or, if unresolved,

(iv) a decision of the Minister for Health in accordance with section 39 of the HHB Act.

66. It is apparent from the evidence that the removal of the responsibility to provide the BAC service was formalised by the execution of the West Moreton Hospital and Health Service – Service Agreement 2013/14-2015/16 Deed of Amendment July 2014. The Deed of Amendment was executed by the chief executive (that is the Director-General of Queensland Health) and the chair of West Moreton HHB, each of who had authority to do so under section 39 of the HHB Act.

67. Logically, the documentation could only occur after the last patient had left the BAC.

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[90] Defined in Exhibit 182 West Moreton Hospital and Health Service - Service Agreement 2013/14-2015/16 LJS.002.0001.0014 at .0017 as:

Relationship Management Group means the body established on the terms of reference agreed by the HHS and Department of Health which routinely reviews and discusses a range of aspects of HHS and system wide performance in accordance with the accountabilities contained within this service agreement. The relationship management group members comprise:

- *the DH-SA Contact Person and the HHS-SA Contact Person;*
- *Executive Directors from the Finance, Clinical Access and Redesign, and Healthcare Purchasing, Funding and Performance Management areas; and*
- *Senior Executive representatives nominated by the HHS, including the Chief Finance Officer, Chief Operating Officer, Director of Performance or equivalent.*

68. Accordingly, it was necessary for the process to be a collaborative one – and it was.

2.4.4 Summary

69. Having regard to the matters outlined above, the State respectfully submits the following:

(a) no one entity had the sole responsibility to make the closure decision;

(b) West Moreton HHS had a legal personality;

(c) West Moreton HHB had control over that HHS, which included the BAC;

(d) the overall responsibility of the public sector health system, pursuant to the HHB Act, was the responsibility of Queensland Health, through the Director-General, as system manager;

(e) the responsibilities of the system manager role include State-wide planning; and

(f) accordingly, West Moreton HHS, via its Board, had the ability to close the BAC. However, in circumstances where the facility in question offered a State-wide service, it would be expected that the system manager would be involved in the decision-making process, to the extent that the decision impacted on State-wide planning.

3. EDUCATION

3.1 The School at Wacol

70. The BAC included an integrated on-site school – the Barrett Adolescent Centre Special School (**School**). This School was unique in that it was not located in a building owned by Department of Education and Training, rather one owned by Queensland Health.[91]

71. The School was created by the Department of Education in the mid-1980s[92] and designated as a '*special school*' to provide education for '*disturbed adolescents*'.[93] It is funded by the Department of Education and Training.[94]

72. During the time the School was located at Wacol, its purpose was to provide educational services to adolescent patients who were in residence or receiving mental health treatment at the BAC at Wacol.[95]

73. The School was located in part of a single building that was also used to deliver the health programs and was adjacent to the residential area for patients.[96]

74. When it was located at Wacol, eligibility for enrolment at the School was linked to the status of the student as a patient of the BAC, that is all inpatients and day patients of the BAC were students of the School.[97]

3.2 The closure decision and the consequences for the School

75. At the time the decision to close the BAC was announced on 6 August 2013, it became apparent that the School would need to relocate.[98]

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[91] Blatch T14-101/L20-30.
[92] Exhibit 25 Affidavit of Peter Blatch para 9.
[93] Exhibit 25 Affidavit of Peter Blatch para 11; Exhibit 134 Affidavit of Patrea Walton Exhibit D – DET.900.001.0001 at .0038.
[94] Exhibit 134 Affidavit of Patrea Walton para 16.
[95] Exhibit 25 Affidavit of Peter Blatch para 12.
[96] Exhibit 25 Affidavit of Peter Blatch para 14.
[97] Exhibit 110 Affidavit of Kevin Rodgers para 12 and 13; Exhibit 106 Affidavit of Deborah Rankin para 40.
[98] Exhibit 134 Affidavit of Patrea Walton para 25; Exhibit 25 Affidavit of Peter Blatch para 31 – 34; Blatch T14-104/L12-27.

76. The Department of Education and Training considered that there was no question of closing the School as:[99]

(a) there were a number of students at the School who were in their senior years of schooling and the ongoing continuity of education provision to those students was a priority;

(b) the prescribed process for closing any state school is a lengthy one, requiring significant consultation; and

(c) in May/June 2014, the Minister for Education made a public announcement that there would be no further closures of schools in Queensland.

77. A small working group was convened by the Department of Education and Training to develop options for possible relocation of the School.[100] The group consulted with relevant stakeholders and were thorough in their deliberations.[101] The factors that determined the most suitable option included:

(a) continuity of educational programs for the students, which was essential;

(b) minimum disruption to the education and well-being of students and staff; and

(c) proximity to the original School location and travel and transport for students and staff.[102]

78. Yeronga State High School was identified as a suitable option for relocation of the School. It was a suitable geographical location, had a separate area / building available which allowed the School to operate independently from Yeronga State High School and was proximate to a local mental health facility and the Lady Cilento Children's Hospital.[103]

[99] Exhibit 134 Affidavit of Patrea Walton para 30 – 32; Exhibit 25 Affidavit of Peter Blatch para 36.
[100] Exhibit 25 Affidavit of Peter Blatch para 37; Exhibit 134 Affidavit of Patrea Walton para 27 – 29.
[101] Exhibit 25 Affidavit of Peter Blatch para 41 – 49.
[102] Exhibit 25 Affidavit of Peter Blatch para 38.
[103] Exhibit 25 Affidavit of Peter Blatch para 40.

3.3 Education transition

79. The principal of the School, supported by the education staff, was responsible for education transition of the students following the closure announcement.[104] Appropriate educational plans could only be developed after the clinical placement of each patient had been negotiated and confirmed.[105]

80. Education transition plans were drafted and developed for each student entitled to schooling under the *Education (General Provisions) Act 2006*.[106] They were approved by the School principal and uploaded into '*One School*' – the Department database.[107]

81. The education transition plans included:

(a) the student's educational history before and during their time at the BAC;

(b) the student's achievements in their subject areas;

(c) the student's achievements in their vocational areas;

(d) unsuccessful educational plans;

(e) information to encourage further learning, strengths and interests;

(f) areas of concern regarding educational outcomes; and

(g) their forward plan.[108]

82. Each transition client's educational needs were reviewed frequently throughout the transition process with individual case conferences held regularly.[109]

83. Members of the education staff were in regular contact with the families and carers of the students,[110] and kept them well informed of the education transition plans.[111]

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[104] Exhibit 25 Affidavit of Peter Blatch para 78.
[105] Blatch T14-106/L16.
[106] Blatch T14-113/L33-42.
[107] Exhibit 25 Affidavit of Peter Blatch para 84; Exhibit 106 Affidavit of Deborah Rankin para 90.
[108] Exhibit 106 Affidavit of Deborah Rankin para 93.
[109] Exhibit 25 Affidavit of Peter Blatch para 87; Exhibit 106 Affidavit of Deborah Rankin para 109.
[110] Exhibit 25 Affidavit of Peter Blatch para 25(b).
[111] Exhibit 107 Supplementary Affidavit of Deborah Rankin para 27.

3.4 The adequacy of support for education staff

84. The education staff at the School received formal notification of the closure of the BAC and the intention to relocate the School on 6 August 2013. This information was conveyed at a meeting at the School.[112]

85. There was no reduction in education staff numbers following the closure announcement.[113] All permanent teachers and teacher aides were guaranteed employment,[114] and staff members who were not permanent at the time were offered permanency.[115]

86. From the time of the announcement, the then Assistant Regional Director, School Performance, Special and Specific Purpose Schools, Mr Blatch met frequently with the principal and the education staff,[116] at which time he re-assured the staff that they would be involved in assisting to shape future educational service options and that their skills were valued and needed.[117] He attended the School in person to inform the education staff of the re-location to Yeronga for 12 months, and to assure the staff that they would be consulted with respect to the need for a subsequent move.[118]

87. Mr Blatch regularly attended the BAC School to provide support for the education staff. He gave the following explanation during his oral testimony:[119]

> *Were you able to do anything – or what could you do and did you do to address your concerns about the staff?---I – I tried to meet with the staff as a whole as frequently as I could or as often as the principal suggested it might be worthwhile. I – I met with the – the principal as required. The principal and the acting principal had set up some, in my opinion, some very, very good care programs for looking after the staff. They had made contact already with our employee assistance program, that they had involved the services of an outside agency to support the staff and I was very impressed with that. The Barrett staff always operated most professionally and I have the highest regard for the way that the principal and the acting principal managed the transition arrangements. I wanted to do everything that I could to support them.*

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[112] Exhibit 134 Affidavit of Patrea Walton para 33.
[113] Exhibit 25 Affidavit of Peter Blatch para 64; Exhibit 134 Affidavit of Patrea Walton para 41.
[114] Exhibit 25 Affidavit of Peter Blatch para 65.
[115] Exhibit 106 Affidavit of Deborah Rankin para 85.
[116] Exhibit 25 Affidavit of Peter Blatch para 8, 27, 28, 29; Exhibit 110 Affidavit of Kevin Rodgers para 36; Blatch T14-113/L16-28.
[117] Exhibit 25 Affidavit of Peter Blatch para 59 and 60. See also Exhibit 106 Affidavit of Deborah Rankin para 88 and Exhibit 107 Supplementary Affidavit of Deborah Rankin para 18 and 19; Rodgers T18-54/L40 – T18-55/L2.
[118] Exhibit 25 Affidavit of Peter Blatch para 52.
[119] Blatch T14-107/L1-21.

88. The acting principal, Ms Rankin, established links with non-government organisations, Headspace and Optum, to provide additional support for the staff at the School.[120]

89. Mr Blatch also invited Ms Bond to attend the School in November 2013 to support staff and provide staff with reskilling opportunities.[121]

3.5 The future provision of education

90. The Department of Education and Training recognises the expertise of Queensland Health officers and mental health experts to provide advice on models of care and the continuum of services suitable in a Queensland context.

91. The Department of Education and Training is committed to providing quality education services to all students, including those with complex mental health conditions.[122] The Department has a continuing commitment to ensure that all students have access to a range of high-quality education and training programs.[123]

92. After the closure of the BAC, the Department of Education and Training retained and expanded education service provision to students with complex mental health conditions.[124] This was achieved through:

(a) continuation of the School, currently located at Tennyson (with onsite classes and outreach services);[125]

(b) delivery of education services to students attending the Child Mental Health Unit, Adolescent Mental Health Unit or day programs at the Lady Cilento Children's Hospital School and similarly to those students involved with the Adolescent Mental Health Unit and day programs at the Royal Brisbane Women's Hospital;[126]

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[120] Exhibit 25 Affidavit of Peter Blatch para 30(b); Exhibit 106 Affidavit of Deborah Rankin para 21; Blatch T14-107/L1-21.
[121] Affidavit of Michelle Bond para 39.
[122] Supplementary Affidavit of Patrea Walton para 3.
[123] Supplementary Affidavit of Patrea Walton para 4.
[124] Supplementary Affidavit of Patrea Walton para 5. See also Exhibit 33 Affidavit of Mark Campling para 47.
[125] For the detail with respect to these services, see Exhibit 33 Affidavit of Mark Campling para 34 to 43 and exhibit F pp 13-17 DET.900.005.0001 at .0030 - .0034; Exhibit 107 Supplementary Affidavit of Deborah Rankin para 74 – 78 and 146 - 148; Rankin T14-90/L17 – T14-91/L3.
[126] Affidavit of Michelle Bond para 12 – 15, 17 – 23 and 30.

(c) the provision of 35.3 FTE and 450 teacher aide hours per week at hospitals at various locations around Queensland to deliver school programs to students in hospital;[127] and

(d) recent allocation of one mental health coach in each of the seven Department of Education and Training regions. These coaches will provide leadership and direction in the planning and implementation of mental health and wellbeing initiatives and priorities within each region. The mental health coaches will also develop and maintain effective networks with internal and external stakeholders to ensure coordinated holistic responses to complex mental health and wellbeing issues; and develop and promote professional development for teachers, school leaders, guidance officers and other staff to enhance staff capability to respond to the needs of students.[128]

93. The Department of Education and Training has also recently established the Students with Complex Mental Health Conditions Advisory Group. The purpose of the Advisory Group is to provide advice to the Department of Education and Training with respect to State-wide co-ordination and delivery of educational services to young people with severe and complex mental health issues.[129]

94. The first meeting of the group was scheduled for 15 March 2016. The membership of the group is Ms Bond (Principal of the Lady Cilento Children's Hospital School), Ms Rankin (Principal of the BAC School), other representatives from the Department of Education and Training, a representative from the Mental Health Commission and child and youth mental health specialists, including Ms Krause from CHQ, as well as representatives from the MHAODB.[130]

[127] See also Affidavit of Michelle Bond para 24 – 28 for further details of the other hospital classes.
[128] Supplementary Affidavit of Patrea Walton para 6.
[129] Supplementary Affidavit of Patrea Walton para 7.
[130] Supplementary Affidavit of Michelle Bond.

95. The aim of the Advisory Group is provided in the Draft Terms of Reference and includes:

(a) to work collaboratively with relevant stakeholders to consider the most appropriate provision of educational services for adolescents with serious mental issues;

(b) to consider the effectiveness of the current provision of educational services for adolescents who have serious mental health issues; and

(c) to provide feedback and advice on any proposed changes to the provision of educational services for adolescents who have serious mental health issues.[131]

96. The work of the Advisory Group will ensure the Department of Education and Training is:

(a) kept informed as to any development or changes to the model of health service delivery provided to students with complex mental health conditions by Queensland Health; and

(b) in a position to provide high-quality education and training services to this group of students into the future.[132]

97. The State submits that, in terms of education, the preference is wherever possible to keep young people with significant mental health needs connected to their local community and their local school. Support should be provided using cross-agency models of care and planning.

98. In some instances this will not be possible, as the student will need to be in a health facility under medical care and supervision. In these instances, it is important that any models of schooling provide an integrated approach between education and health that promotes the wellbeing of the student. It will be imperative that medical support, for example child and youth psychiatrists and other mental health clinical staff, are readily available within the education setting to provide support and medical advice.

[131] Supplementary Affidavit of Patrea Walton para 9 and exhibit B pp 7 – 9.
[132] Supplementary Affidavit of Patrea Walton para 10.

99. If a student is in a facility under medical care, it is important that links are made with the school where the student has been enrolled. This is to assist with connection to local community and the transition back to school when the student leaves the facility.

3.6 Summary

100. Having regard to the evidence outlined above, the State respectfully submits the following:

(a) the Barrett Adolescent Centre Special School did not close;

(b) the decision by Department of Education and Training to relocate, rather than close, the School was appropriate;

(c) the decision to relocate the School to Yeronga was well-informed and was reasonable in the circumstances;

(d) the education transition was appropriate;

(e) the Department of Education and Training supported their education staff through this process, including by:

(i) regular attendances by Mr Blatch; and

(ii) temporary staff being transitioned to permanent positions;

(f) appropriate educational services are responsive to relevant services provided by Queensland Health; and

(g) the Department of Education and Training has recently established the Students with Complex Mental Health Conditions Advisory Group. The purpose of the Advisory Group is to provide advice to the Department of Education and Training with respect to State-wide co-ordination and delivery of educational services to young people with severe and complex mental health issues.

4. TRANSITION ARRANGEMENTS FOR TRANSITION CLIENTS

4.1 Transition clients

101. Paragraph 3(d) of the terms of reference for the COI states:

> *3(d) for BAC patients transitioned to alternative care arrangements in association with the closure or anticipated closure, whether before or after the closure announcement (**transition clients**):*
>
> *i. how care, support, service quality and safety risks were identified, assessed, planned for, managed and implemented before and after the closure (**transition arrangements**); and*
>
> *ii. the adequacy of the transition arrangements;*

102. The question of who are '*transition clients*' is a matter of fact to be determined by the COI with reference to all of the evidence.

103. At its widest, the transition clients were those clients who were in-patients, day patients or waiting list patients of the BAC from 20 November 2012, when the potential closure was first publicly mentioned, to the date the BAC was finally closed.

104. The transition clients were provisionally identified by Counsel Assisting in a list provided during the hearings.[133]

105. A number of those clients captured by the definition in paragraph 103 above already had transition or discharge plans in place prior to the closure announcement on 6 August 2013. To that extent, although they are within the scope of the terms of reference for this COI, it is submitted that the arrangements for those clients are not material to the findings and recommendations of this COI.

4.2 The responsibility for implementing the transition arrangements

106. The transition arrangements were all arrangements made by the BAC staff (clinical and educational) to ensure that there was a seamless continuum of care and appropriately planned ongoing educational provision for the transition clients. The adequacy of the transition arrangements vis-à-vis ongoing education provision is dealt with in Section 3.3 above.

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[133] Confidential Working Draft - Potential transition client list current as at 1 March 2016.

107. The responsibility for transition arrangements is more readily appreciated with consideration of the structure of various committees in place at the time. The committee structure with regard to terms of reference, membership and reporting relationship was outlined in the affidavit material of Ms Adamson.[134] There is a complete list at exhibit ZD to that affidavit.[135]

108. As is demonstrated by the list of members of the committees, there was support, information sharing and clear lines of communication throughout the transition process and the development of the new suite of services between CHQ and West Moreton HHS.

109. The transition arrangements were, at all times, the principal responsibility of the transferring service, that is West Moreton HHS.[136] In addition to that principal responsibility, the receiving service was also responsible to work with West Moreton HHS and the transitioning client to ensure a seamless transition and transfer of care.

110. From the evidence heard at the recent public hearings it appears most likely that no closure related transition planning had in fact taken place before Dr Brennan was appointed to the role of Acting Clinical Director on 10 September 2013, following the standing down of the long term Clinical Director Dr Sadler. No adverse inference against Dr Sadler is indicated by that submission.

4.3 Adequacy of transition arrangements

111. Dr Brennan worked with a small group of clinical staff to develop appropriate transition plans for each of the transition clients. There were individual plans for each client. Each client was transitioned to an appropriate receiving service.[137]

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[134] Exhibit 14 Affidavit of Ingrid Adamson para 42, 105.
[135] Exhibit 14 Affidavit of Ingrid Adamson para 105.
[136] For example: Exhibit 41 Affidavit of Dr Mary Corbett para 29.2, Corbett T9-48/L20-25; Exhibit 49 Affidavit of Ms Dwyer para 22.3 and 22.5, Dwyer T12-99/L43 – T12-100/L4 ; Exhibit 66 Affidavit of Ms Kelly para 18.1 – 18.19; Exhibit 55 Affidavit of Dr Geppert para 11.2 – 11.6 and 12.1 – 12.2, Geppert T10-32/L35-40; Exhibit 122 Affidavit of Associate Professor Stathis para 31, Stathis T24-42/L18-27; Exhibit 14 Affidavit of Ms Adamson para 9-11 and 68, Adamson T25-48/L4-15; Exhibit 125 Affidavit of Dr Steer para 6 – 9 and 55 , Steer T24-113/L10-16.
[137] Exhibit 71 Affidavit of Associate Professor Beth Kotze p 41; Exhibit 14 Affidavit of Ingrid Adamson p 1627.

112. It is submitted that Dr Brennan and her team worked very hard to develop individual plans for each of the transition clients. In particular, they:

(a) identified appropriate services including non-government organisations (**NGOs**);

(b) considered possible alternative care options; and

(c) consulted with transition clients and their families and carers throughout the planning and transition process.[138]

113. Counsel Assisting's submissions focus on the final clients that were transitioned from the BAC.[139] The last clients to be transitioned were In light of Counsel Assisting's submissions some comment should be made about the adequacy of the transition arrangements for the final four transition clients.

4.3.1

114.

115.

[138] Exhibit 71 Affidavit of Associate Professor Beth Kotze p 217.
[139] See, for example, paragraph 380, 474, 490 and 491 to 677.
[140] Affidavit of Dr Emmerson, para 7; Affidavit of Dr Williams, para 9(c).

116.

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118.

[141] Exhibit 28 Affidavit of Dr Brennan para 115(c), Brennan T20-56/L20-23; Exhibit 71 Affidavit of Associate Professor Kotze para 112, Kotze T23-26/L26-39, T23-28/L21-34.
[142] Exhibit 28 Affidavit of Dr Brennan para 74.
[143] Presumably this is equivalent to '*authorised*' pursuant to the *Mental Health Act 2000*.
[144] Statement of Samantha Smith.

119. The final paragraph of Counsel Assisting's submissions on this point, at paragraph 605, again demonstrates a lack of understanding of the operation, in practice, of the MH Act. The community category of the ITO remains an authority to prescribe treatment to a patient.

120. The final sentence of paragraph 605 states that:

121.

122.

123.

124.

[145] Exhibit 92 Affidavit of Ms Karen Northcote para 9.
[146] At paragraph 610.

125. The evidence before the COI supports a finding that higher-level nursing supervision funding arrangements were agreed between West Moreton HHS, Metro North HHS and MHAODB and the funds were provided.[147]

126. It is further submitted that it was never established by Counsel Assisting that the funding or ongoing therapy arrangements after transition were within Dr Brennan's knowledge or responsibility. It is submitted that there is no evidence that Dr Brennan has such knowledge; it is clear that she did not have any of the administrative responsibility for transfer of funds. For that reason it is submitted that the submission by Counsel Assisting on this issue be rejected.

127. At paragraph 625 of Counsel Assisting's submissions, it has been submitted that the explanation for the cessation of the higher level of nursing supervision provided by Metro North HHS to Associate Professor Kotze does not provide an adequate explanation of the basis for that decision. In response it is submitted that Associate Professor Kotze was satisfied that the clinical decisions taken by Metro North HHS were clearly decisions for which they were responsible and an experienced and multi-disciplinary team led by a senior consultant psychiatrist was best placed to make such decisions. The receiving service could not be bound by the transferring service weeks after responsibility for clinical care had been transferred.[148]

128.

[147] Exhibit 71 Affidavit of Associate Professor Kotze para 112 and Exhibit F p 11 and Appendix C – Patient B.
[148] Kotze T23-55/L17-27.

129.

130.

4.3.2

131.

132.

[149] QHD.011.001.0001; QHD.011.001.0002; QHD.011.001.0003; Exhibit 71 Affidavit of A/Professor Kotze at para 46(a), 94-95 and 103 and exhibit AA.
[150] Simpson T21-100/L32-33; Brennan T20-41/L9-23.
[151] Exhibit 116 Affidavit of Ronald Simpson para 65 and 66; Exhibit 21 Affidavit of Julie Beal para 13 – 22 and 42 - 47.

133.

134.

135. Paragraph 530 of Counsel Assisting's closing submissions provides as follows:

(b)

(c)

(d)

(e)

136.

137.

[152] Exhibit 116 Affidavit of Ronald Simpson para 34, 35, 39 – 42, 43 - 52; Exhibit 21 Affidavit of Julie Beal para 13 – 22 and 42 - 47.
[153] Exhibit 116 Affidavit of Ronald Simpson para 69 - 73; Simpson T21-102/L1-22.
[154] Exhibit 116 Affidavit of Mr Simpson para 68-69, Simpson T21-102/L1-22.

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4.3.3

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148.

[155] Exhibit 61 Affidavit of Ms Hart para 8 – 14; Exhibit 128 Affidavit of Dr Tovey para 7 – 9, 13; Exhibit 98 Affidavit of Ms Palmer para 9 – 10, 14 – 16; Exhibit 44 Affidavit of Ms Curtis para 6.

149.

150.

151.

152.

4.3.4

153.

154.

[156] Exhibit 61 Affidavit of Ms Hart para 18 – 22; Exhibit 128 Affidavit of Dr Tovey para 13 – 20; Exhibit 98 Affidavit of Ms Palmer para 23 – 24; Exhibit 44 Affidavit of Ms Curtis para 9 – 16.

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[157] For example, see Exhibit 82 Affidavit of Janet Martin.

4.3.5 Waitlist

160. Dr Brennan, in consultation with Associate Professor Stathis of CHQ, followed up the treatment options for waiting list clients.[158] All waiting list clients, or their referrer and/or family or carer, were contacted and there was appropriate information sharing and planning for the transition clients on the waiting list. None of the young people on the waiting list required admission as a result of the BAC closure.

161. In Counsel Assisting's submissions at paragraph 457 there is criticism of CHQ and Associate Professor Stathis' evidence in light of CHQ being unable to offer services to BAC waitlist clients. Associate Professor Stathis' evidence on that point is clear. West Moreton HHS had the overarching responsibility to manage the wait list. Counsel Assisting appear to perceive an inconsistency on this issue between the evidence of Dr Steer and Associate Professor Stathis.

162. It is submitted that the apparent perception of Counsel Assisting in this regard is misguided. There is a difference between '*operational governance and responsibilities for on-going services*' and '*clinical responsibility*'. As was explained by Associate Professor Stathis, CHQ has a geographical remit (metropolitan Brisbane) for which it has clinical responsibility. In addition, CHQ has a State-wide remit, or '*operational governance*' responsibility, for high-level issues dealing with care coordination, education and development.[159]

4.3.6 Summary regarding adequacy of transition arrangements

163. None of these transition clients outlined in some detail above needed a subacute bed.

164. A mapping exercise relating to the demand for mental health services (including support services) for young people 16 to 24 would be of assistance with specific

[158] Exhibit 122 Affidavit of Associate Professor Stathis para 53 – 54; Exhibit 28 Affidavit of Dr Brennan para 7, 164, 165(k), AB-11 p 26.
[159] T24-104/L20 – T24-106/L3.

attention being given to accommodation issues for young people with mental illness who are not subject to orders pursuant to child protection legislation.

4.4 The role of CHQ

165. All of the evidence with respect to transition arrangements demonstrates that West Moreton HHS had the overarching clinical responsibility for the transition arrangements.[160] All of the evidence with respect to development of new services demonstrates that CHQ had responsibility for the development of the new suite of AMHETI services.[161]

166. Following the BAC closure announcement, CHQ worked with West Moreton HHS[162] to ensure open lines of communication between the two services to:

(a) support the transition planning process by ensuring West Moreton HHS was aware of the progress of the development of the new services;

(b) to provide professional support to Dr Brennan; and

(c) to provide oversight and approval of wraparound funding for any of the transition clients who required such funding.

167. CHQ began investigating what new services were considered most appropriate to provide the necessary treatment options for young people (aged 13 to 17) across the State before the closure of the BAC.[163] In doing so, they built on the work already undertaken by the Expert Clinical Reference Group (**ECRG**).[164]

168. Multiple steering groups and committees were established to design and implement the development of the new suite of services. All of these steering groups and

[160] For example: Exhibit 41 Affidavit of Dr Mary Corbett para 29.2, Corbett T9-48/L20-25; Exhibit 49 Affidavit of Ms Dwyer para 22.3 and 22.5, Dwyer T12-99/L43 – T12-100/L4 ; Exhibit 66 Affidavit of Ms Kelly para 18.1 – 18.19; Exhibit 55 Affidavit of Dr Geppert para 11.2 – 11.6 and 12.1 – 12.2, Geppert T10-32/L35-40; Exhibit 122 Affidavit of Associate Professor Stathis para 31, Stathis T24-42/L18-27; Exhibit 14 Affidavit of Ms Adamson para 9-11 and 68, Adamson T25-48/L4-15; Exhibit 125 Affidavit of Dr Steer para 6 – 9 and 55 , Steer T24-113/L10-16.

[161] For example: Kelly T11-31/L1-29; Exhibit 14 Affidavit of Ms Adamson para 9-11, exhibit C; Adamson T25-48/L4-15; Stathis T24-34/L1-18; Exhibit 125 Affidavit of Dr Steer para 56.

[162] For example: Geppert T10-32/L42 - T10-35/L28, T10-58 /L1–26, T10-59/L40 - T10-60/L34; Dwyer T12-107/L9-18; Exhibit 14 Affidavit of Ms Adamson para 9-11 and 47, exhibit C, exhibit M, Adamson T25-47/L1 – T25-48/ L47, Exhibit 72 Affidavit of Ms Krause, para 37, Stathis T24/38/L19-26, Exhibit 125 Affidavit of Dr Steer para 9 – 11.

[163] Working Group 1 - Stathis, T24-37/L4-19, Exhibit 14 Affidavit of Ms Adamson, para 42(a) and 101 -104 exhibit P, exhibit ZC.

[164] Stathis T24-35/L1 – T24-36/L43.

committees were multi-disciplinary and led by CHQ.[165] They reported to the Chief Executive and Department of Health Oversight Committee, whose membership included key West Moreton HHS staff.[166]

169. When developing the planned suite of services, CHQ and West Moreton HHS appreciated that the preferred services could not be fully operationalised in the short-term.[167] It takes considerable time to identify necessary services, develop a model of service delivery, procure an agreement with a service provider and staff the service before operationalising and opening a new service.[168] As was explained by Associate Professor Stathis in his oral testimony:[169]

> *... the project plan wasn't endorsed – or wasn't given in-principle endorsement by the board of CHQ until November 2013. It would've been reckless to go ahead with un-trialled new services with an unknown workforce until endorsement of that plan was provided by the board.*
>
> *We were working under the processes of Queensland Health, and despite our best intentions, those processes to employ new workers take time. We have to develop role descriptions, establish the role, then we have to advertise, we have to recruit, we have to then – and then the – the successful applicants have to come on board. For example, the AMYOS teams have two allied health or nursing positions and appoint two psychiatrists. A psychiatrist has to give a minimum of three months' notice before moving to a new hospital and health service. So these things take time. We worked as hard and as quickly as we could within the constraints of Queensland Health and the HR system*

170. CHQ developed a business case for the new suite of services. That business case was approved by the CHQ HHB.[170] It was appreciated at that time that there were elements of the suite of new services that were not fully funded. In addition, it was appreciated that funding for new capital works (i.e. for the Step Up/Step Down units or for a new build for sub-acute beds) was not immediately available.[171]

171. CHQ communicated the new suite of service options under development and the timelines for each of those across the State.[172]

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[165] Exhibit 14 Affidavit of Ms Adamson, para 42 - 45, exhibits F, P – R.
[166] Exhibit 14 Affidavit of Ms Adamson, para 97 – 100, exhibit N; Exhibit 125 Affidavit of Dr Steer para 28 – 33.
[167] Geppert T10-26/L1-7; Dr Steer T24-115/L30-41; Dr Cleary T14-33/L25.
[168] For example: Stathis T25/47/L1-37.
[169] Stathis T24-47/L10-30. The transcript refers to '*appoint two psychiatrists*'. This should be a reference to *'0.2FTE*'.
[170] Exhibit 14 Affidavit of Ms Adamson, para 121, Exhibit ZK; Adamson T25-52/L21-37; Exhibit 125 Affidavit of Dr Steer, para 59, exhibit G.
[171] Stathis T24-40/L11-42, T-24-48/L28-47; Exhibit 73 Affidavit of Ms Krause para 10(h)(i).
[172] Exhibit 14 Affidavit of Ingrid Adamson, para 110 – 115 Exhibit F (SWAETRIS Steering Committee Minutes) Exhibit H (SWAETRIS project status reports) ZE, ZF and ZG (communication), Exhibit 125

4.5 Subacute beds

172. One issue that received attention at the public hearings was the timing of the availability of the subacute beds at the Mater Hospital,[173] that is, whether these beds were available prior to the closure of BAC or following the actual date of closure.

4.5.1 Availability of subacute beds

173. In meeting minutes, referred to in the evidence, it was often recorded that the subacute beds at the Mater Hospital were available from February 2014.[174]

174. Professor McDermott gave evidence that the beds were generally available, although no formal process had been agreed.[175] He stated that had there been a need for a subacute bed for a transition client prior to February 2014, a bed could and would have been made available.[176] The exact date of closure of the BAC was unknown and not within CHQ control when initial discussions occurred between Associate Professor Stathis and Professor McDermott regarding subacute beds.

4.5.2 Knowledge of the availability

175. Professor McDermott gave oral evidence that he had made it clear to a number of key individuals at CHQ and West Moreton that Mater CYMHS was available to assist with the BAC transition process. He stated that he had conversations with Ms Krause, Associate Professor Stathis, Dr Geppert and Dr Brennan as follows:

> *Again, I just – I want to know who you spoke to, who you made it clear to? Well, I think I'm a pretty good communicator. I think I made it clear to everybody, but certainly Dr Stathis, certainly Judy Krause, depending – I'd have to get the timelines right – depending on where this fits with the Queensland Children's Hospital. I know there were conversations with Leanne Geppert, who you've mentioned. I made it clear that we were willing to be very helpful about relocation of patients.*[177]

Affidavit of Dr Steer para 59, exhibit G (CHQ HHBoard papers); Exhibit 72 Affidavit of Ms Krause, para 41, Exhibit Q (Central Mental Health Clinical Cluster meeting minutes), Exhibit S (State-wide Child and Youth Mental Health Alcohol and Other Drugs Clinical Group meeting minutes); Geppert T10-28/L23-26.

[173] For example: McDermott T7-28/L20-30; Exhibit 84 Affidavit of Professor McDermott para 117 exhibit BMCM-14; Geppert T10-27/L30 – T-28/L41; Kingswell T13-25/L20-26; Stathis T24-48/L8 – T24-49/L12, T24-50/L8-25, T24-91/L26-39.

[174] Exhibit 14 Affidavit of Ms Adamson, exhibit F – minutes of meeting on 2/12/2013 (p 277) and January 2014 Committee Paper (p 312).

[175] McDermott T7-28/L20-30.

[176] McDermott T7-43/L4-22 andT7-60/L11-18; Kingswell T13-25/L20-30; Exhibit 14 Affidavit of Ms Adamson, para 30, exhibit L (memo from Ms Kelly dated 22/10/13); QHD.012.001.1689.

[177] McDermott T7-32/L20-17; Dr Kingswell T13-25/L23-26.

> ...
>
> *So insofar as you refer then to that conversation with Dr Brennan, is that, again, as a result of your misunderstanding or imperfect recollection about who it was that you were speaking to about [redacted] I think the – it can, as read, stand alone in that in terms of our interaction, it was often not document. It was often an interaction between professionals that was a discussion and that I've made the point that it was often informal, which was the truth. I made it known to Dr Brennan that Mater CYMHS was happy to be of assistance which we've talked to and I stand by that. So I think number 119 doesn't have to relate to any particular patient and could stand as is.*[178]
>
> ...
>
> *Yes. Thank you. Reverting back then to paragraph 119, the response that you've given me about what that related to draws upon, does it, your belief that you would have at some point in time in conversation with Dr Brennan, assured her that the Mater CYMHS was happy to be of whatever assistance it could be? That's correct.*[179]

176. In her evidence, Dr Geppert confirmed that it was her understanding that subacute beds were available at the Mater and later at the Lady Cilento.[180]

177. Dr Cleary was also aware of the existence of the subacute beds. He had been informed of them by Dr Steer.[181]

178. With respect to this issue, Dr Steer gave evidence as follows:[182]

> *In term of the tier 3 beds at the Mater Hospital, you said that – and we can see that in paragraph 60 – that the tier 3 beds were available at the Mater from February 2014. And I think that the evidence was that you gave to Counsel Assisting was that the formal process took a bit longer or – I don't want to put words in your mouth – something to that effect. Could you explain that, please?---Well – well, look, I have – through a long history and certainly in a parallel activity in the establishment of the LCCH hospital which was going at the time I had an enormous amount to do with the Mater and planning services. I can speak with confidence that the Mater Children's Hospital were committed to supporting from February 2013. What took some further time to do, which is not unusual, was the formal agreement written and signed around that particular process. I think I can speak – and I know I can speak with confidence about the Mater's approach in attitude, that they were certainly available, and I – I know that Dr Stephen Stathis and the clinical leadership at the Mater had spoken about, and very deliberately about, the different model of care that would be required for this subacute service at the Mater Children's, as opposed to their acute inpatient service. So this was, in fact, a very, very deliberate piece of work, to be available by [indistinct]*
>
> *So when you say the tier 3 beds were available at the Mater from February 2014, why didn't the formal process also finalise in February 2014? Can you explain*

[178] McDermott T7-37/L20-25.
[179] McDermott T7-38/L15-18.
[180] T10-27/L30 – T10-29/L33.
[181] Exhibit 40 Statement of Dr Michael Cleary para 125; T14-44/L18-46.
[182] T24-121/L1-38.

> *that process?---I think the – for reasons which may not be understood, but – and I hate the word bureaucratic, but the time taken, even between individual hospital and health services to sign agreements around transfer of funds and performance relationships is extended and unusually long. I can't explain it. It's disappointing, but it takes time. As evidence about that, it was a number of months before, as I remember it – I can't remember the exact timeline – where it took us considerable time to sign off with Metro South Hospital and Health Service around the transfer of funding and the running of the AMYOS teams out of Metro South. One tries to be respectful about governance arrangements with these, that they are embedded in the local services, but one also has to make sure, getting back to the original questions, about budget integrity, and, in fact, there's a clear understanding that given this money is available for this particular cohort of patients that it stays it, agreements, formal agreements become important. They take some time to do. They take even longer, often, and, unfortunately, with the Mater Hospital. So it's actually just that process of detailing how both the agreement, the funding, and, in fact, the performance indicators will be monitored going forward. As I've said, to be fair to the Mater, my relationship with them was incredibly positive, and I know for a fact that they were certainly available to look after this cohort if necessary from February 2014.*

179. Associate Professor Stathis stated that in November 2013 he liaised with Professor McDermott about making subacute beds available at the Mater.[183] He also gave evidence that the subacute beds were available prior to the closure but were not needed.[184]

180. With respect to this issue, Associate Professor Stathis explained that on 22 October 2013, a memo was sent from Ms Sharon Kelly to all chief executives and clinical directors of services across Queensland stating that:

> *Children's Health Queensland (CHQ) has commenced work with stakeholders from across the State to develop the future model of adolescent extended treatment and rehabilitation services. Further information about these developments will be provided by CHQ ion the near future. Until then, please contact Dr Stephen Stathis on* [redacted] *o discuss any clinical issues for patient who may require extended mental health treatment and rehabilitation and are unable to be managed within your health service'.*[185]

181. On this issue, the submissions of Counsel Assisting at paragraph 456 are disrespectful. To say that Associate Professor Stathis '*asserts*' that a memo was sent is particularly offensive given the COI has a copy of the email and attached memorandum and have had for some time.

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[183] T24-50/L10-15.
[184] See also Exhibit 40 Statement of Dr Michael Cleary para 125, 126, 137 and 138.
[185] See Exhibit 14 Affidavit of Ms Adamson, para 30, exhibit L (memo from Ms Kelly dated 22/10/13); QHD.012.001.1689.

182. Further, Associate Professor Stathis stated that he had made the existence of subacute beds known to the profession during the RANZCP faculty meeting on 26 November 2013. His evidence about that was as follows:

> *On 26 November 2013 I presented the whole suite of services to the quarterly meeting of the faculty of child and adolescent psychiatrists, the most senior child and adolescent psychiatrists within the State. And I outlined the suite of services that were available, including beds within the Mater.*[186]

183. It is noted that Counsel Assisting's submissions and language on this point imply a predisposition against Associate Professor Stathis' evidence.[187]

184. Dr Brennan gave evidence that she was unaware that the subacute beds were available prior to the closure of the BAC.[188] It is noted that Dr Brennan was a recipient of the email and the attached memo sent by Ms Kelly on 22 October 2013.

185. Further, notwithstanding that Dr Brennan has stated that she had no knowledge of the subacute beds when she was transitioning the BAC clients, she has stated that there were three options offered to [redacted] that is the Mater unit, the Toowoomba unit and the Townsville unit.[189] That being so, it is submitted that there is no doubt that Dr Brennan knew that the Mater beds were an option for the BAC patients prior to the closure of the unit. It may be that Dr Brennan was considering the Mater unit option for Ms Yandell as an acute transfer; that is one possibility. It is submitted that there is no need for the COI to reconcile this anomaly.

186. Dr Brennan also states that had she known of the availability of the subacute beds she would have '*considered including them in the transition plans for patients such* [redacted] However immediately thereafter Dr Brennan states that as [redacted] shortly after the date of closure of the BAC, and given that the level of deliberate self-harm that [redacted] engaged in was distressing to co-patients at the BAC, Dr Brennan's opinion was that an

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[186] Stathis T24-49/L4-8.
[187] See para 456 where it is submitted that '*Associate Professor Stathis purports to have spoken about the subacute beds*.' See also paragraph 180 above.
[188] Affidavit Sharon Kelly at SK-19 – Email and memo referred to by Associate Professor Stathis as the memo that indicated to all Clinical Directors that any difficulty with placement of young people due to closure of the BAC was to be directed to him. Dr Brennan was a recipient of that memo.
[189] Second Supplementary Statement of Dr Anne Brennan para 24.

admission to the Mater subacute beds would have been '*extremely distressing to young children*.' It is submitted that there was no delay in [redacted] ransfer as a result of Dr Brennan's stated lack of knowledge of the availability of subacute beds at the Mater.

187. Dr Brennan also stated that most of the older adolescents were not on a normal developmental trajectory before their admission to the BAC. After lengthy admissions their development had been further delayed.

188. It is submitted that both Associate Professor Stathis and Dr Brennan are eminent child and youth psychiatrists. Both are highly regarded within the profession in Queensland and in other States. They have given conflicting evidence in regards to the issue of knowledge about the availability of the subacute beds. It is submitted that there is insufficient evidence to support any finding on this issue one way or the other.

189. If the COI intends to make a finding[190] that Dr Brennan was unaware of the availability of the subacute beds, and that such knowledge was material to the process of transition, the State submits that time should be set aside to test this evidence more thoroughly given that Dr Brennan's statement outlining this information was provided after Professor McDermott and Dr Geppert gave evidence. Further, additional evidence may need to be adduced. It is noted that, in addition to Dr Brennan and Associate Professor Stathis, 25 other eminent child psychiatrists attended the RANZCP faculty meeting on 26 November 2013 and statements should be taken from each of those attendees before any such finding could be made. Following receipt of these statements, hearings may need to be reopened to properly address these issues.

190. It is further submitted that the differences in the recollection of Associate Professor Stathis and Dr Brennan of discussions that occurred over two years ago is an insufficient basis for the submissions made by Counsel Assisting:

(a) at paragraph 453 that '*the strategy for nominating "conduits" and "status updates" may have been a poor substitute for direct communication between the relevant parties*'; and

[190] It is submitted that no such finding needs to be made – see section 4.5.3.

(b) at paragraph 455 that '*there is evidence of certain deficiencies in communication and the development of an escalation process for consumers whose needs fell outside the existing service options*'.

191. To the contrary, there is overwhelming evidence that there was good communication and good co-ordination between CHQ and West Moreton HHS. That evidence is addressed in detail in Section 4.6.

4.5.3 No transition client needed a subacute bed

192. It is further submitted that the COI does not need to make a finding as to whether or not Dr Brennan knew of the availability of the subacute beds prior to the closure of the BAC. It is submitted that none of the transition clients needed a subacute bed before February 2014. That submission is supported by the investigation findings and the evidence of Associate Professor Kotze.[191]

193. In consideration for the need for the subacute beds prior to the closure of the BAC, the last three patients to be transitioned were also amongst the most complex of the young people of the BAC cohort. None of those young people required a subacute bed in order to facilitate their transition. Their transition arrangements were somewhat delayed for various reasons. It is submitted that none of those reasons reflect the need for a subacute bed.

194. [redacted]

[191] Exhibit 71 Affidavit of Associate Professor Kotze para 72 and Exhibit F (Appendix D); Kotze T23-56/L4-15; Stathis T24-48/L12-21.

195. [redacted]

196. [redacted]

4.5.4 Subacute beds in an acute ward

197. As to the suitability of the availability of the subacute beds at the Mater as a long term solution to the closure of BAC, it is submitted that there is sufficient evidence before the COI to support a finding that there has been very little demand for the subacute beds since BAC closed and that subacute occupancy of the available beds has been low. The reason for that is unknown.

198. It is further submitted that it is not ideal that young people with chronic and severe patterns of mental illness who require a longer admission to a subacute unit be admitted to an acute unit.[193] There is a need for a focussed subacute rehabilitation service. The precise model that such a service should reflect is not yet clear. The Youth Mental Health Commitments Committee (**YMHCC**) will continue to investigate site and model of service options and recommendations from that group should be forthcoming as a matter of urgency.

[192] Second Supplementary Affidavit of Dr Brennan, para 12.

[193] Despite it not being ideal, it is irresponsible for Counsel Assisting to submit, as they do in paragraph 114, that '*given the expert views regarding the likelihood of deleterious effects on both cohorts, it is difficult to imagine any child and adolescent psychiatrist referring a sub-acute patient to the acute ward.*' It is clear that there have been referrals (see Exhibit 176 para 10 and 11) and the COI has no evidence to suggest that the referral (and admittance) to the subacute beds was deleterious to any of the patients.

4.6 The interaction between West Moreton and CHQ

199. It is apparent from a number of propositions put to a number of witnesses that Counsel Assisting was exploring the support and interaction between West Moreton HHS and CHQ. One example is the following questioning of Dr Geppert:

> *...the responsibility for implementing the transitioning arrangements rested with West Moreton Hospital and Health Service with oversight from its board. Do you have a view on that proposition?---I agree that the clinical transition packages that were developed for individual young people moving from Barrett or being discharged from Barrett were the responsibility of West Moreton Hospital and Health Service.*[194]
>
> *...the performance of these two responsibilities – and that is looking at the previous two propositions I put to you – seems, at least on one view, to have occurred in isolation. Have you got a view on that, Dr Geppert?---I strongly disagree with that statement.*[195]

200. Dr Geppert went on to explain that CHQ and West Moreton HHS worked together:

> *It was quite clear that from that particular time, we would work side by side. We demonstrated that. We communicated regularly around all relevant issues in both formal and informal forums.* [196]

201. Dr Geppert gave evidence that the development of the new service options did not occur in isolation, with respect to the SWAERTI Committee Dr Geppert said that there was, '*... two way direction, information from West Moreton and information from that committee back to West Moreton*'.[197] Dr Geppert also stated that she was in almost daily contact with Ms Adamson from CHQ in relation to correspondence.

202. At or around the date of closure the balance of the operational budget for BAC was transferred to CHQ. MHAODB transferred additional funds on a '*one off*' basis. The purpose of the funds was for the set up and operational costs of the new services.

203. CHQ worked collaboratively with West Moreton HHS in a number of key respects during the development of the new suite of services[198]. A number of committees were established. The memberships of these committees, listed in Ms Adamson's affidavit material, demonstrates strong and consistent collaboration between West

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[194] Geppert T10-32/L35-40.
[195] Geppert T10-33/L37-10.
[196] Geppert T10-33/L16-19.
[197] Geppert T10-33/L15-45.
[198] Exhibit 14 Affidavit of Ingrid Adamson at pp 1547 – 1548.

Moreton HHS and CHQ during both the transition period and the development of the new services period.

204. CHQ provided professional support for Dr Brennan via Dr Hoehn. Dr Hoehn met with Dr Brennan weekly on a Wednesday morning to discuss the transition plans and they met later on Wednesdays with Dr Geppert.[199]

205. CHQ provided after hours psychiatric consultancy cover following Dr Brennan's appointment to the role of Acting Clinical Director.

206. Ms Adamson provided a significant degree of direction and support from an administrative perspective. She was responsible for the development of the business case. Ms Adamson was also the responsible secretariat on the committees.

207. Ms Adamson assisted West Moreton HHS with the preparation of Ministerial briefing notes[200], Ministerial response drafts, memoranda to HHS' and correspondence drafts. This ensured that consistent messages were provided to the recipients of the documents from both West Moreton HHS and CHQ.

208. Associate Professor Stathis provided support to Dr Brennan on an '*as needs*' basis. They closely collaborated in relation to the management of the BAC waiting list clients.

209. Counsel Assisting at paragraph 453 submits that the strategy of nominating conduit status updates may have been a poor substitute for direct communication between the relevant parties.

210. Such a submission ignores the content of the very memorandum that Counsel Assisting refers to in paragraph 456. This is the memorandum that advises clinical staff to contact Associate Professor Stathis.

211. Accordingly, as of October 2013, whilst the transition of BAC patients was underway, Associate Professor Stathis made it clear to Executive Directors and Clinical Directors of Mental Health Services that they could directly communicate

[199] Exhibit 64 Affidavit of Dr Elisabeth Hoehn; Hoehn T19-23/L39-45; Brennan T20-20/L45; T20-21/L46 to T20-22/L2.
[200] For example, Exhibit 14 Affidavit of Ingrid Adamson at pp 1570, 1575, 1683, 1793.

to him about clinical issues for patients who may require extended mental health treatment and rehabilitation.

212. It must be appreciated that '*the relevant parties*' that Counsel Assisting are referring to are professional psychiatrists who have clinical responsibilities for their patients. If any psychiatrist had a patient who required any extended mental health treatment and rehabilitation that could not be managed within their health service, which would include a subacute bed, then it would be expected that they would contact Associate Professor Stathis.

213. This memorandum sets up direct lines of communication between Clinical Directors who '*are on the ground*' treating patients and Associate Professor Stathis.

214. Further Associate Professor Stathis states he told 26 eminent psychiatrists (including Dr Brennan) at the Faculty of Child and Adolescent Psychiatry of the RANZCP Queensland meeting on 26 November 2013 that there were subacute beds available at the Mater.[201] Such sharing of information in this forum would constitute direct communication between the relevant parties.

215. It is clear on this point that Counsel Assisting have quickly dismissed Associate Professor Stathis' evidence out of hand, without checking with any of the other psychiatrists at the meeting. Counsel Assisting's predisposition on this point is unfortunate.

216. Memories may certainly differ as to what was discussed at the RANZCP Queensland meeting; that is to be expected after over two years. It is submitted to make such serious credit findings against Associate Professor Stathis, an eminent psychiatrist, is not open on the state of the evidence. This issue should not be framed as a credit contest between Associate Professor Stathis and Dr Brennan. Memories may differ, but that is not a basis to make adverse findings with far reaching consequences against either.

217. Counsel Assisting's submission in paragraph 455 should be struck out or withdrawn. This paragraph acknowledges that it is not the role of the COI to

[201] Stathis T24-49/L1-12 ad T24-50/L10-15.

determine a causal link between any deficiencies in the management of the risk and any critical incident that occurred before the development and rollout of service options; despite such an acknowledgement, Counsel Assisting are not deterred from forging into this area and then making a serious allegation. It must be noted that the state of the present evidence is:

(a) at best a '*he said – she said*' situation between Associate Professor Stathis and Dr Brennan;

(b) evidence from other witnesses that has not been investigated;

(c) Professor Kotze's evidence that even if the suite of AMHETI services was all up and running at the time it would have made no difference to the transition plans because of the bespoke nature of the individual plans; and

(d) none of the deceased required a subacute bed.

218. Further as discussed previously the COI does not need to make a finding as to whether or not Dr Brennan knew of the availability of the subacute beds.

4.7 Brokerage funding arrangements

219. The Young People's Extended Treatment and Rehabilitation Initiative Governance Committee[202] commented on the availability of some funds for brokerage funding support.

220. Brokerage funding was also discussed in the materials before the COI as '*Consumer Transition Support*', specifically when referring to additional funding support for [redacted] There are a number of pieces of correspondence, memoranda, and draft Ministerial documentation with respect to this issue.[203]

221. Ms Krause has stated that the oversight of the BAC operational funds was transferred to CHQ upon closure of the BAC. She was informed of requests for additional funds for the ongoing support of former BAC clients from the client's treating HHS.[204]

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[202] Exhibit 14 Affidavit of Ingrid Adamson p 1249 (YPETRI minutes 15 Jan 14)
[203] Exhibit 72 Affidavit of Judi Krause p 348, 351
[204] Exhibit 72 Affidavit of Judi Krause para 53 and exhibit 'U' is a bundle of emails regarding transition brokerage funding requests received by CHQ.

222. MHDOAB also transferred funds to CHQ to additionally support the transitioning of the transition clients.[205]

4.8 The findings of the Kotze/Skippen report

223. The report authored by Associate Professor Kotze and Ms Skippen was forwarded to Queensland Health on 30 October 2014. The investigation was completed over a period of approximately 10 weeks. Extensive documentation was reviewed by the two expert investigators appointed to undertake the investigation. The third member of the investigation team was a non-clinician, Ms Geddes, a legal practitioner.

224. The report recognised a number of limitations as follows:

(a) the investigation was limited to review of the available documentation and interviews with key clinicians formerly from the BAC. Staff of receiving services were not interviewed and limited documentation was available from these services. Education Department staff, associated with the BAC, were not interviewed; and

(b) a senior nurse who had a key role in the transition planning process declined an interview with the investigators.[206]

225. The report made many findings with a single recommendation.

226. In further explanation of the limitations of the investigations it is submitted that the COI should appreciate that:

(a) the provision for a health service investigation under the HHB Act did not enable the investigators to compel evidence from outside Queensland Health;

(b) the scope of the terms of reference for the investigation focussed upon the appropriateness of the transition planning; and

(c) there was a concern to not impact the pending coronial investigation.[207]

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[205] Exhibit 82 Affidavit Janet Martin para 14 - 18, 21, 23, 25, 26, 34 and various exhibits to that affidavit.
[206] Exhibit 71 Affidavit of Associate Professor Beth Kotze p 36.

227. Key findings of the investigation led by Associate Professor Kotze were that the BAC team undertook an exhaustive and meticulous process of clinical review and care planning with each individual young person's best interests at the core of the process. Despite the pressure of a looming deadline, there was evidence that the first and critical emphasis of care was to establish and provide good clinical care including addressing physical health needs. The transition plans, without exception, were thorough and comprehensive. The process of communication and negotiation between the clinical team and the young person and their family/carers was careful, respectful, timely and maintained. There were numerous examples of the BAC staff working in a collaborative way with receiving agencies.[208]

228. Associate Professor Kotze and Ms Skippen confirmed that the governance model put in place within Queensland Health to manage the oversight of the health care transition plans was appropriate. The key findings included:

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

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

(c) available minutes and agendas of meetings indicate regular frequency of meetings and the involvement of carers and patients in decision-making.

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

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[207] The reasons for the scope of the investigation were adequately explained in Exhibit 40 Statement of Dr Michael Cleary at paragraph 209-211 and in Exhibit 53 Statement of Kristi Geddes at Exhibit KG-47.
[208] Exhibit 71 Affidavit of Associate Professor Beth Kotze pp 40-41.

230. In relation to the timeframes given for the process of transition planning to be developed and enacted, it is noted that the deadline was achieved albeit with a sense of pressure and urgency for the clinical staff especially towards the end.

231. All transition plans were individual for all transition clients.[209]

232. It is submitted that there were no questions put to Associate Professor Kotze that would support any criticism of the findings of the report.

4.9 Summary

233. Having regard to the evidence outlined above, the State respectfully submits:

(a) West Moreton HHS was responsible for transition arrangements;

(b) all transition plans were reflective of individual patient need;

(c) all transition clients were transitioned to appropriate services;

(d) CHQ was responsible for development of the AMHETI suite of services;

(e) CHQ and West Moreton HHS worked closely and effectively to communicate the progress of the transition arrangements and the progress for the development of the new AMHETI suite;

(f) the terms of reference and membership of all committees and sub-committees is reflective of high level collaboration and cooperation between both CHQ and West Moreton HHS and also the key stakeholders;

(g) the subacute beds at the Mater Children's Mental Health Unit were available before the closure of BAC but were not needed; and

(h) brokerage funding was available to all transition clients if needed.

[209] Kotze T23-56/L5-15.

5. ALTERNATIVE SERVICES

5.1 The planned suite of services

234. The ECRG membership was a diverse group including senior child and adolescent psychiatrists, an educational representative and consumer and carer representatives. The Planning Group was also a diverse group, which included an educational representative. There was cross-membership between the two groups: Dr Geppert was a member of both groups. The Planning Group reviewed the ECRG recommendations and submitted them to the West Moreton HHB with a number of identified additional considerations and recommendations.[210]

235. Counsel Assisting put to a number of witnesses that there was a need for alternative models of care to replace the BAC. Those questions appeared to suggest that the new suite of AMHETI services ought to have been operational before the closure of the BAC.

236. It is not in dispute that the transition clients were in fact transitioned to adult services or existing CYMHS services. For that reason, it is submitted that it is irrelevant whether the new AMHETI suite of services was operational before the closure of the BAC.[211]

237. As Associate Professor Kotze stated in her oral evidence, the transition clients were not the focus of the new suite of services in the following terms:

> *And in this model of – in these – with this suite of services, which I understand you would consider contemporary services? Comprehensive.*
>
> *Where and which Barrett patients would have fit into those services? So if they had been available, for example, when the Barrett closed, would you have seen some of the patients – particular patients had gone to any – had gone to some of those particular services? It's both sort of a simple question and a quite complex question, in that yes, some of those services might have been one of the options considered under that care element, bearing in mind that for each of the young people it was possible to identify specific care elements under each – elements under each heading. There's another question, though, in what you're asking, I think, which is that when you're seeking to create all the options of a contemporary service model, you're really in general thinking about – and this is very general – three kind of populations. So you're thinking about a population that has been – has experienced the system as it has existed with, perhaps, its*

[210] Exhibit 72 Affidavit Judi Krause pp 253 – 257.
[211] Kingswell T13-53/L32 – T13-54/L23; Stathis 24-46/L8-18; Exhibit 72 Affidavit of Ms Krause, para 87-86.

> *limitations, perhaps its practices or settings that are perhaps more conducive to disability rather than rehabilitation and recovery. You're talking about a population – a second population that is perhaps starting to get into the system and is on that trajectory, where there's perhaps the greater ability to turn around that clinical course and the onset of disability. And then, of course, you've got the population that's yet to come into the system that will benefit from the full range of contemporary service options. So I think when you're talking about the Barrett population, yes, some of those options would have been reasonable, but you're also talking about a population where no one service element in a contemporary system is going to fit because you have particularly difficult and complex patients with a trajectory already in train.*
>
> *And, in fact, that's – in your report, you say these are not the kind of individuals who readily fit with service systems because of the scope and intensity of their needs? Yes, and part of that is around their disability.*[212]

238. With respect to this issue, Counsel Assisting, at paragraph 294, submit that:

> *Little, if any, weight ought to be afforded Associate Professor Kotze's evidence on this point. It is highly speculative and general. On her own evidence, she only looked in detail at* [redacted] *Further, it does not take into account either the co-morbidity of the transition clients nor some of their 'dysfunctional' family background.*

239. The stated basis for the submission is incorrect. Associate Professor Kotze and Ms Skippen examined transition plans for all transitioning clients of the BAC but gave closer attention to the [redacted] with the most complex needs.[213]

240. Further, Associate Professor Kotze gave clear evidence that:[214]

> *... So I think when you are talking about the Barrett population, yes, some of those options would have been reasonable, but you are also talking about a population where no one service element in a contemporary system is going to fit because you have particularly difficult and complex patients with a trajectory already in train.*

241. She clearly appreciated the complexity and co-morbid issues of the transition clients.

242. The Chair of West Moreton said in her oral evidence that, '*we were assured that there was no gap in service and that appropriate wraparound services were available*'.[215] Dr Geppert stated that the development of the new range of services was being led by CHQ.[216] Ms Dwyer stated in her oral evidence that West Moreton HHS concentrated on the transition plans for the transition clients.[217]

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[212] Kotze T23-54/L43 – T23-55/L25.
[213] Exhibit 117 Affidavit Ms Skippen para 20(a); Exhibit 71 Affidavit Associate Professor Kotze para 74.
[214] T23-55/L18-20.
[215] Corbett T9-50/L1-4.
[216] Geppert T10-32/L42-44.
[217] Dwyer T12-99/L46 – T12-100/L4.

243. Dr Corbett also spoke of the new service development being in '*a parallel sense*' not the focus of West Moreton HHS because the governance of the new State-wide model of care was the responsibility of CHQ.[218] Dr Corbett also stated in her evidence that she understood transition of the transition clients to be to existing services.[219] Dr Cleary was of the same understanding. In his mind there were two processes running in parallel, and the transition clients requirements were to be met with '*wraparound care*', which may involve contracting with a variety of service providers to tailor care specific to each patient.[220]

244. CHQ was provided with the balance of the BAC operating budget to stand up the new suite of services.

245. CHQ invested a great deal of effort, before and after the closure of the BAC, exploring options and developing new models of service.[221] There were many meetings and updates provided to CHQ Executive and Board.

246. CHQ and West Moreton HHS co-facilitated a Working Group workshop, involving a range of key stakeholders, to assist with the development of the new suite of services. That workshop was provided with the ECRG recommendations as a starting point for the design of the new services.[222]

247. A business case to support the implementation of the new suite of services was developed by CHQ.[223] That business case was presented to the CHQ Board for initial approval and escalated thereafter to Queensland Health in July 2014. It was known that there was no available funding for any capital projects within the business case at that time.

248. The business case was developed over time with version 0.1, the initial draft, dated 27/11/13 and version 3.0 dated 2/4/14 incorporating input from the CHQ executive team and Queensland Health who were kept closely informed of its development over time.[224] The model of care was developed in accordance with the National

[218] Corbett T9-60/L27-33.
[219] Corbett T9-79/L7-10.
[220] Cleary T14-33/L12-41.
[221] Exhibit 14 Affidavit of Ms Adamson para 119 – 120, exhibit ZI and ZJ, exhibit F (Steering Committee TORs and minutes).
[222] Exhibit 14 Affidavit of Ms Adamson para 101 – 105, exhibit P, ZC and ZD; Adamson T25-48/L17-23.
[223] Exhibit 14 Affidavit of Ms Adamson para 121, exhibit ZK.
[224] Exhibit 14 Affidavit of Ms Adamson exhibit ZK (version 3.0 - p 8294).

Mental Health Services Planning Framework. New service options and expanded existing service options were included in the business case.

249. CHQ also developed a State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Project Plan and Communication Plan.

250. Establishment of the new services remained the responsibility of CHQ. Service agreements, including key performance indicators, were developed by CHQ.

251. Multiple sources reflect the development of the business case suite of services (AMHETI). The various ways the suite of services was being progressed was also the subject of multiple documents including meeting minutes and agendas.

252. The anticipated timeline for the new services was not one that envisaged provision of the new services to the BAC cohort, that is apart from the Youth Resi at Greenslopes, which was home to one ex-BAC patient when it opened in February 2014.

253. Aspects of the AMHETI business case remain unfunded. The YMHCC is exploring options in relation to the demand and model of service delivery for subacute beds. This is discussed in more detail in section 5.4. The business case demonstrated that there was a need for new capital funding to deliver the Step Up Step Down Units.

254. In relation to the suite of AMHETI services presently available, evidence was adduced before the COI that demonstrated that there are a number of new services across the state as follows:[225]

(a) AMYOS – 9 teams across the State;

(b) Resi Rehab – 4 rehabilitation facilities across the State (1 x Cairns, 2 x Townsville and 1 x Greenslopes); and

(c) Day Program – Toowoomba, Townsville, Lady Cilento Children's Hospital and Brisbane Northside.[226]

[225] Exhibit 292 - CHQ map of services across Queensland.
[226] Brisbane Northside was the only day program established with AMHETI funding. The other day programs were pre-existing.

255. There are four subacute swing beds available at the Lady Cilento Children's Hospital. The availability of these subacute beds for young people with severe and complex mental health issues was always intended to be a short to medium term solution. The AMHETI suite business case included bed-based elements of service i.e. Step Up Step Down Units.

256. The subacute swing beds are funded operationally as acute beds. To date there has been no specific funding allocated for the provision of subacute beds at Lady Cilento Children's Hospital or in any other location across the State.

257. Despite the meticulous planning that CHQ undertook in developing the business case, a number of elements of the AMHETI suite of services have not yet been operationalised or recurrently funded. These include the three Step Up Step Down units and the subacute bed based unit.

258. The business case envisaged an age range over 18 years for the youth resi rehab component. There is discussion across the sector at present regarding the appropriateness of extending the age range in certain AMHETI service elements. No final model of service delivery as yet reflects any agreed change to the upper age limit. This extended age range issue is also a component of the YMHCC work, which is continuing.

259. The oral evidence regarding the AMHETI suite was remarkably consistent. All psychiatrists were in support of it.

(a) Dr Breakey gave evidence that he considered such service '*valuable*'. He also said that he and Dr Sadler had been asking for AMHETI like services for many years.[227]

(b) Dr Sadler welcomed the resi rehab units and said that he had been advocating for a range of services for young people in Queensland many years.[228]

(c) Professor McDermott accepted that the new suite of service was comprehensive and did more than meet the needs of the BAC cohort: it met

[227] Breakey T6-40/L35 – T6-41/L31.
[228] Sadler T17-34/L15–17, T17-35/L4-11.

the greater needs across the State. Professor McDermott also stated in his oral evidence that the suite was '*impressive*' and he identified the added advantage that it had been replicated across the Far North of Queensland. He supported treatment for young people closer to their home.[229]

(d) Dr Groves supported the suite of services saying that the suite was a comprehensive suite if applied right across Queensland.[230]

(e) Associate Professor Scott accepted that the suite improved the options for young people.[231] Although he was initially unaware of the detail of the range of planned and available services, once they were outlined to him, he appreciated the services contemplated he supported the suite of services completely.[232]

(f) Dr Kingswell said that the suite '*ticked off*' against all of the intended outcomes of the National Mental Health Strategic Planning Framework.[233]

(g) Associate Professor Kotze said the suite was comprehensive and contemporary.[234]

(h) Dr Fryer was not aware of the rollout of the new suite of services but in her submission to the COI submitted that protracted admissions of adolescents to inpatient facilities is the antithesis of the strategic direction of mental health service delivery in Australia.[235]

(i) Professor Martin said the suite was '*the beginnings of a comprehensive program which has a continuum of care, which has checks and balances in it.*'[236]

(j) Associate Professor Stathis was one of the main authors of the AMHETI suite; he is unsurprisingly a supporter of it.[237]

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[229] McDermott T7-54/L1-6 and L20-22 and T7-55/L33-45.
[230] T7-82/L44 – T7-83/L2.
[231] T8-11/L45 – T8-12/L10.
[232]T8-9/L32 – T8-13/L2.
[233] Kingswell T13-55/L42 – T13-56/L27.
[234] Kotze T23-9/L4-26.
[235] Exhibit 144 Submission of RANZCP p 1; T25-13/L3-6.
[236] Martin 25-34/L11-47.
[237] Stathis T24-90/L5-33.

260. Associate Professor Stathis led the AMHETI team and was described by Professor Martin as follows:[238]

> *He's an exceptional child psychiatrist. I have to say he's an exceptional person as well. And behind that I would like to say that he's an exceptional paediatrician. He's got the double qualification. I don't actually know that much about his paediatrics so I can't really comment on that but he is, I believe, highly intelligent, highly capable and he's going to do great things for this State.*

5.1.1 Communication of the AHMETI suite to families at the BAC

261. At paragraphs 699, 701 and 710 of Counsel Assisting's closing submissions there is an assertion that the families of the transition clients were not consulted or informed with regard to the development of the AMHETI suite. It is also asserted that without the strong advocacy of parents that the parents would not have been invited to present at the SWAERTI committee meeting on 30 September 2013. That assertion is rejected as no such proposition was put to the relevant witnesses during the hearings. It is accepted that is the view held by

262. A review of the documentation demonstrates that the development of the AMHETI suite included the input from the Working Group 1 workshop. That workshop was held on 1 October 2013. It was widely attended. Specific feedback from parents and carers was invited to inform the work of the Service Options Working Group.[239] A parent submission was received by the State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy. Following receipt of the written submission the parent representatives were invited to present to the SWAERTI committee.[240] Parent representatives presented to the steering committee on 4 November 2013.[241] Associate Professor Stathis and Dr Steer had a meeting with on 7 November 2013.[242]

263. Paragraph 703 of Counsel Assisting's closing submissions states that there was a parent information session held at the Park on 10 December 2013. That

[238] T25-43/L5-9. See also T25-42/L10-40.
[239] Letter from Ms Kelly to Parents and Carers dated 30 September 2013 – attached to Ms Adamson's affidavit at page 1385. See also the list of members for Working Group 1 which included consumer and carer representation.
[240] Affidavit of Ingrid Adamson at page 271; Affidavit of Laura Tooley Exhibit LT-18.
[241] Exhibit 14 Affidavit of Ms Adamson, para 63, exhibit W; Adamson T24-49/L25 – T25-50/L6; Exhibit 122 Affidavit of Associate Professor Stathis, para 42.
[242] Exhibit 122 Affidavit of Associate Professor Stathis, para 42; Exhibit 14 Affidavit of Ms Adamson, para 64, exhibit W.

presentation was on 11 December 2013. Associate Professor Stathis presented the proposed AMHETI suite, which was still being developed.[243]

264. Whilst it is not in dispute that the AMHETI suite was not '*stood up*' prior to the closure of the BAC it is submitted that the evidence does not support a finding that the BAC families ought to have been more involved or more informed with regards to the development of the AMHETI suite.

5.2 The need for a facility to replace BAC

265. In their submissions, Counsel Assisting identified the '*first fundamental issue*' as '*Was there, and is there, a need for a facility like the BAC or its proposed replacement at Redlands*'.[244] With respect to that issue, Counsel Assisting have:

(a) summarised the evidence of the psychiatrists who gave evidence and submitted:

(i) there were '*no significant differences in their views*'; and

(ii) that considerable weight should be given to the opinions of Associate Professor Scott and Professor Hazell;[245] and

(b) concluded that:

> *It follows that the specialist expert advice, including those who designed the Queensland Plan for Mental Health 2007-2017 and the members of the ECRG, all accepted that a design-specific and clinically staffed bed-based service is essential for adolescents who require medium term extended care and rehabilitation.*
>
> *... they were nevertheless convinced that a Tier 3 facility is essential as there is a small group of young people whose needs cannot be safely and effectively met through alternative service types.*

5.2.1 The evidence of the experts about the need for a sub-acute facility

266. The extracts of the expert evidence provided by Counsel Assisting, while accurate, do not make reference to a number of key acknowledgments by the experts, particularly with respect to qualifications or concessions made by the experts as to the limits of their knowledge. Acknowledgment of each of the expert witness'

[243] Exhibit 14 Affidavit of Ms Adamson, para 65-66, Exhibit X; Stathis T24-41/L14 – T24-42/L3; Exhibit 122 Affidavit of Associate Professor Stathis, para 42.
[244] Paragraph 13 of Counsel Assisting Submissions.
[245] Paragraph 15 of Counsel Assisting Submissions.

limits on their knowledge is essential in determining the probative value of their respective opinions and each expert witness' evidence should be read as a whole to give proper context to their opinion on this matter.

Associate Professor Scott

267. In the evidence of Associate Professor Scott, when Ms Wilson QC took Associate Professor Scott through the proposed suite of services being developed in Queensland, Associate Professor Scott admitted having no experience with the Resi services. With the addition of Resi services in the suite of services described to Associate Professor Scott, he was happy to recant his evidence that he did not think the suite of services would meet the needs of the young people he identified at paragraph 80 of his statement.[246]

268. Further when cross-examined with regard to the benefit of providing a Tier 3 service in the future Associate Professor Scott replied:[247]

> *"…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 other alternatives might be before investing such a large sum of money into such a facility."*

Professor Hazell

269. Professor Hazell gave evidence that he believed there to be an '*unmet need in the community*'. He noted that his opinion was based on his knowledge of national and international literature; that he was not aware of the two[248] residential rehabilitation services available and that he was not aware of the proposed step up step down unit to commence in Cairns in 2017.[249]

270. In Counsel Assisting's submissions there is a quote that Professor Hazell supported a Tier 3 service because a lack of such a service would create '*bed block'* for acute inpatient units. The evidence before the COI is that the rates of occupancy in acute adolescent units in Queensland are not high,[250] beds are generally available and the

[246] T8-12/L29 - T8-13/L2.
[247] T8-27/L28-31.
[248] In fact there are four Resi Rehabs available in Queensland.
[249] T8-40/L44 – T8-41/L12.
[250] Kingswell T13-83/L1-24.

uptake in respect to the available subacute beds at the Mater Hospital and now the Lady Cilento Children's Hospital has been low.[251]

271. As has been demonstrated above Professor Hazell has limited knowledge of the current suite of available services and no knowledge of the proposed services, waiting funding, in Queensland. It is submitted that his evidence should be viewed in this context.

Professor McGorry

272. Professor McGorry's evidence should be properly viewed in the context of the limited material made available to him by Counsel Assisting prior to providing his statement. Professor McGorry confirmed[252] that the only material he was provided was:

(a) a draft model of service for the Adolescent Extended Treatment and Rehabilitation Centre that had been planned for Redlands;

(b) the statement of Dr Sadler;

(c) the statement of Dr Brennan; and

(d) the statement of Professor Crompton.

273. Professor McGorry acknowledged that his knowledge of the Queensland services presently available or planned for the future was limited to the material he had been provided and that he was not '*familiar in detail with what currently is on the books*'.[253]

274. When responding to questions relating to the need for inpatient facilities focussing on extended treatment and rehabilitation, Professor McGorry stated that such services were necessary. Professor McGorry stated, in his affidavit, that any rehabilitation facility for '*damaged, disabled, developmentally regressed and disconnected*' emerging adults was one component of a broader suite of community services including step up step down units.[254]

[251] Exhibit 123 Affidavit of Associate Professor Stathis; Stathis T24-50/L22-25, T24-67/L27-30.
[252] T18-7/L21-27.
[253] T18-7/L29-32.
[254] Exhibit 56 Affidavit of Professor McGorry para 52.

275. Professor McGorry was not a supporter of the BAC model of care. He described the BAC as '*stand-alone and located in a heavily institutionalized and stigmatized setting, utilising what sounds like a typically old fashioned approach to such inpatient care*.'[255]

Dr Breakey

276. Dr Breakey's evidence should be considered in light of his limited knowledge of both contemporary residential rehabilitative services and the AMHETI suite.[256] The fact that Dr Breakey believed that AMYOS was a useful '*stop gap*' for the BAC[257] suggests that Dr Breakey is unaware of the role of AMYOS, he is unaware of the planned AMHETI suite and also unaware of the supporting rationale for the models of service delivery that underpin the suite of AMHETI services.

Dr Groves

277. Dr Groves gave evidence that he has not practised in the Queensland system since 2012.[258] He further explained that he has not maintained detailed knowledge about the suite of services provided to the Child and Youth Mental Health Services in Queensland.

278. When questioned about his understanding of the proposed continuum of services being developed in Queensland, after hearing the evidence of Professor McDermott, Dr Groves stated:

> *It's a suite of services that covers the various different elements that, if added together, from a planning perspective should meet the needs of the group of people who you're targeting*[259]

279. He further stated that he believes the suite of services, if they were comprehensive and applied across Queensland, would provide the services he referred to in paragraph 98 of his statement.

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[255] Exhibt 86 Affidavit of Professor McGorry para 48.
[256] T6-40/L1-16.
[257] Exhibit 172 Supplementary Affidavit of Dr Breakey Supplementary para 33.
[258] T7-81/L23-27.
[259] T7-82/L39-42.

Weight to be afforded to Associate Professor Scott and Professor Hazell

280. Having regard to the evidence referred to above, it is submitted that the evidence of Associate Professor Scott and Professor Hazell should not be singled out as preferred.

281. It is submitted that, when considering this issue, the Commissioner should give careful consideration to all of the evidence available including the evidence of the other eminently qualified experts such as Associate Professor Stathis, Dr Brennan, Associate Professor Kotze, Professor Martin, Dr Kingswell and Dr Fryer.

Associate Professor Stathis

282. Associate Professor Stathis has detailed knowledge of the proposed suite of services available and he is clearly highly regarded by his peers.

283. As noted above, Professor Martin described Associate Professor Stathis as follows:[260]

> *He's an exceptional child psychiatrist. I have to say he's an exceptional person as well. And behind that I would like to say that he's an exceptional paediatrician. He's got the double qualification. I don't actually know that much about his paediatrics so I can't really comment on that but he is, I believe, highly intelligent, highly capable and he's going to do great things for this State.*

284. Dr Steer described Associate Professor Stathis in the following way:[261]

> *And certainly I do want to commend the leadership of Stephen Stathis and Judy Krause, not only their talent but I think their style that enabled people to come together to ensure that in fact the services, even if not ideal, were responsive to placing together what really were bespoke packages not just for the planning of the discharge and transition and – and transition of the current Barrett patients at the time but also, obviously, for that cohort of patients across the state through 2014. And I mean, I obviously may have not been in the loop but I think to be fair this collaboration across the state and the fact that Stephen Stathis and his team provided both a consultant, supportive and in fact an assessment process for admission to the resi and the subacute beds at the Mater I think was a huge step forward in making sure that there was a coordinated patient path for this particular clientele. I think the fact that the subacute beds at the Mater Hospital, as I understand it, were literally used by only one patient on two occasions over that – I think the 10 month period. I'm not quite sure I have any recall after October would suggest to me – and again, I have no other evidence that kids or adolescents were falling through the cracks – that in fact we had a – a system in place and a very thoughtful process in place to look after this cohort.*

[260] T25-43/L5-9. See also T25-42/L10-40.
[261] T24-120/L1-17.

285. It should be noted that the submission of Counsel Assisting at paragraph 64 should be disregarded. Different witnesses react in different ways and the characterisation of Associate Professor Stathis by Counsel Assisting as '*antagonistic*' attempts to reduce (and thus diminish) Associate Professor Stathis' expert opinion evidence to a matter of credit based on perceived demeanour.

286. The COI would be better assisted by considering Associate Professor Stathis' expertise and the exemplary reputation he holds within the profession when considering the content of his evidence.

Dr Brennan

287. Dr Brennan has detailed knowledge of the circumstances of transition for the transition clients.

Associate Professor Kotze

288. Associate Professor Kotze has knowledge of the circumstances of transition for the transition clients and has detailed knowledge of the work being undertaken on the National Mental Health Service Planning Framework.

Professor Martin

289. Professor Martin, a retired consultant psychiatrist with many decades of experience in child and adolescent psychiatry stated that throughout his career he *'... always tried to manage young people outside of an inpatient setting, if at all possible.'*[262]

290. Counsel Assisting's closing submissions at paragraph 46 submit that Professor Martin's opinion regarding the '*desirability*' of extended treatment and rehabilitation for a similar cohort to the BAC should be given little weight because Professor Martin has not had contact with the BAC since 2004/2005. That submission is perplexing as many of the consultant psychiatrists upon whom Counsel Assisting are seeking to rely have had no contact with BAC whatsoever. Counsel Assisting's submissions regarding Professor Martin should be rejected.

[262] Exhibit 81 Affidavit of Professor Martin para 3.

Dr Kingswell

291. Dr Kingswell is one of the most highly respected psychiatrists in Queensland. He is the Director of MHAODB and has held high-level positions in mental health in Queensland for many years. When asked about the need for a Tier 3 service Dr Kingswell said:

> *A tier 3 service should be prioritised; so did you agree with that?---Yes.*
>
> *And if we scroll down to heading 3 – so one more page down, please – you can see the recommendation I took you to:*
>
> *A tier 3 service should be prioritised.*
>
> *?---Yes.*
>
> *Did you agree with that?---I wasn't happy with the language, but I was happy with the intent.*[263]

292. Dr Kingswell went on to state that:

> *…and I just thought it would have helped if we had a consistency of language, and so tier 3, I thought, was – I didn't – I don't think I actually got it for a while either, that I didn't – in fact, maybe I still don't – whether it's a build or a – or a service; that – that possibly still remains a little bit unclear for me. So, yes, I – it was completely comfortable with the idea that we needed extended inpatient facilities for a group of adolescents, tier 3, whatever you call it. Yes.*[264]

293. As can be seen from Dr Kingswell's responses he remains unclear as to whether a new building is actually required or if a Tier 3 service can be delivered without a new building.

294. He was a strident critic of the BAC; he described it as '*a dangerous, violent place, and I'll hold to that*.'[265]

295. Dr Kingswell also provided evidence as to the risks of institutionalisation and stigmatisation as potential outcomes of long stay units as follows:

> *… a number of people have made the point that the services being offered within the Barrett Adolescent Centre were out of date, possibly not evidence-based and – but the more overriding concern was that the young people that were housed in that facility were housed there for months and years and sometimes two, three years.*[266]

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[263] T13-23/L23-30.
[264] T13-23/L45-13-24/L5.
[265] Kingswell T13-42/L37-38.
[266] T13-62/L10-13.

and later,

> *Well, it's quite likely that you will come into that Centre at a point of time with a set of skills. They might be from your education or whatever. After two years in that Centre of having your meals prepared, your clothes washed, your bed made, all of your relationships are peculiar in that they're constrained to a group that share serious mental disorder with you, that you're miles away from family and school and other social connections – it's likely to be quite a disturbing experience I would have thought and you will emerge from that with none of the skills that you came in with.*
>
> *Is it your professional opinion that one can emerge damaged by the experience of that type of therapeutic environment?---I don't want to mention any of the cases.*
>
> *No.?---You can find that in the files of the case.*[267]

296. There is no reason to doubt that Dr Kingswell was aware of the issues with the model of care at the BAC and there can be no doubt that it is his belief that long stay inpatient units for young people are highly damaging to their recovery.[268]

Dr Fryer

297. Dr Fryer also gave both written and oral evidence to the commission. Dr Fryer is a highly regarded and experienced child and adolescent psychiatrist. As Counsel Assisting correctly cites, Dr Fryer stated that the BAC cohort might have had their needs met if more intensive community services were available.[269]

298. Dr Fryer is aware of the current suite of services being progressively '*stood up'* around Queensland. She is aware that the full suite is not yet available. Dr Fryer stated that she thought that the suite of AMHETI services, presumably when fully operationalised, may reduce or even remove the need for subacute beds.

299. Dr Fryer was concerned with the risk of institutionalisation that is inherent in any medium stay, rehabilitation facility. She stated that admissions of 3 to 6 months were preferable and that longer lengths of stay carried risks of institutionalisation and '*iatrogenic increase in disability'*. [270]

5.2.2 The need for a design-specific and clinically staffed bed-based service

300. As is noted in paragraph 265(b), Counsel Assisting submit that all members of the ECRG were convinced that a Tier 3 facility is essential.

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[267] T13-62/L26-38.
[268] T13-62/L27-33.
[269] Exhibit 144 RANZCP submission.
[270] Exhibit 288 RANZCP supplementary submission.

301. The terms bed-based service and Tier 3 facility may be interchangeable, but a Tier 3 service is not necessarily an inpatient bed-based service, and care should be taken not to conflate a '*service*' with a '*facility*'.[271]

302. As was explained by Dr Geppert:[272]

> *... there was no funding for a replacement bricks and mortar service to be developed. That didn't mean, of course, that we couldn't develop models of service and ways of delivering care to that particular cohort, but there was no capital funding to actually build a bricks and mortar building.*

303. It is submitted that it is not apparent from the face of the ECRG report that the requirement for a '*Tier 3 service*' equates to a requirement for '*bricks and mortar*'.[273]

304. As was explained by Professor Hazell, a member of the ECRG, whilst a new build was off the table, this was not antagonistic to the idea of developing a model of care that involved tier 3 services. There remained possibilities such as refurbishment of an existing facility or alternative accommodation for the service.[274]

305. Ms Callaghan, another member of the ECRG, also explained that in her opinion, a tier 3 service does not need to be an inpatient unit like the BAC.[275]

5.2.3 Risks associated with institutionalisation

306. It is acknowledged that the evidence of many of the psychiatrists was that, even with the full AMHETI suite, there might be a residual need for a bed-based unit for a small group of young people. The relevant evidence in this respect is summarised in Counsel Assisting's closing submissions.

307. However, what is notably absent from the submissions of Counsel Assisting with respect to the need for a bed-based subacute service is the countervailing evidence of the risks associated with long lengths of stay.

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[271] Counsel Assisting's closing submissions conflate these concepts on a number of occasions. See, for example, para 82, 87, 94 and 269.
[272] T10-15/L17-22.
[273] With respect to this issue, see Cleary T14-20/L30 – T14-21/L40.
[274] T8-33/L32-46.
[275] T8-58/L44 – T8-59/L6.

308. When considering the issue of the need for a bed-based subacute service, it is important not to lose sight of the careful balance that needs to be struck to protect against the risk of institutionalisation. Associate Professor Kotze evidence on this issue is of particular assistance:[276]

> *And can you just explain to the Commission what is meant by institutionalisation in the mental health context?---Okay. I can certainly talk to the – the topic in the light of current experience within New South Wales. So within New South Wales, as a result of the development of a plan by the New South Wales Mental Health Commissioner, it has been determined that New South Wales will complete the process of institutionalisation – de-institutionalisation that was become some decades ago. As part of that, the definition has been defined as people staying in a hospital setting for longer than 365 days, and this setting is a – is a whole of life setting, if you like, where the person is a patient within a context, that a whole variety of their needs are met, so they don't actually need to leave that setting in order to have those needs met, and this results in an acquiring of a disability that may affect that person's ongoing life.*

And:[277]

> *MS MUIR: In paragraph 18 of your statement, you describe institutionalisation as creating the risk of enduring or even lifetime disadvantage through disruption to a young person's functioning and psychosocial development. I just – going back to your knowledge of the – well, understanding of the Barrett Centre, at this point in time now, would it be fair to say that you had a – you have a good understanding of how the Barrett Centre operated?---Yes, I do believe I have acquired an understanding. Yes.*
>
> *And so are you able to explain to the Commission how institutionalism in a setting like the Barrett Centre may lead to enduring or lifetime disadvantage?---The – the significant issue for – for young people is that when their development is disrupted or goes off-track it's very difficult for them to recover that ground later on down the line. So for these young people, they were spending very long periods of time in an artificial environment where imposed on them was the role of patient, so there's the sense of things being done to them, and a relative relinquishment of decision-making and a sense of autonomy and – and responsibility. There – so they don't have the opportunities to acquire at the appropriate development stage the life experience and the developmental capacities that will enable them to then function well as – as adults. It's compounded by the artificial nature of an institution, that kind of whole of life idea, that there isn't the requirement to plan activities of, you know, ordinary living, to actually interact out in the community. Things come to you when you're in an institution. There's also the particular quality of relationships, and I think that there was certainly quite a lot of evidence in the files of the kind of regressive relationships in very high-intensity and high-dependency environments. And it is the sense that because that's such a significant part of the young person's life and it's a very long time in a young person's life, three – two to three years, that that imprint is very strong then for the young person moving into adulthood, and it's quite difficult to redress, unless it's very specifically redressed, perhaps in a program of rehabilitation etcetera.*

[276] T23-5/L33-44.
[277] T23-6/L8-36.

309. As is submitted in paragraph 198 above:

(a) there is a need for a focussed subacute rehabilitation service; and

(b) the precise model that such a service should reflect is not yet clear.

310. It is submitted that the risks associated with institutionalisation should be left to be considered by YMHCC as part of its process of refining the precise model for such a service.

5.3 Potential gaps

311. It was well-recognised by the psychiatrists that there are potential gaps in:

(a) the alignment of adolescent and adult services;[278]

(b) the services available for dual diagnosis clients, that is clients with mental health issues co-morbid with an intellectual disability (or even co-morbid with substance misuse issues);[279] and

(c) the availability of forensic/secure beds for adolescents with mental health issues.[280]

312. It was generally accepted that, before articulating what services may be needed, it would be appropriate to undertake a service mapping exercise to:

(a) understand the differences between current services available in CYMHS versus adult mental health services;

(b) identify service needs for specific age groups (such as 13-18; 16-21; 18-25);

(c) identify potential groups in service delivery for these age groups; and

[278] See, for example, McDermott T7-56/L1-16; Kingswell T13-56/L29 – T13-57/L5; Sadler T17-47/L24-26. See also Exhibit 71 Affidavit of Associate Professor Beth Kotze para 117 and Kotze T23-23/L34 – T23-24/L22 regarding the difficulties in aligning adolescent and adult mental health services.
[279] See, for example, Sadler T17-48/L9-18; Brennan T20-63/L1-6; Kotze T23-44/L6-16; Stathis T25-7/L35-41.
[280] See, for example, McDermott T7-57/L1-13, who recognized the gap but indicated that demand was low. Exhibit 123 Affidavit of Associate Professor Stathis, para 21; Crompton T7-14/L1-15.

(d) form an options paper for discussion between all relevant stakeholders, including representatives from the MHAODB, Office of the Chief Psychiatrist, Mental Health Commissioner, CYMHS and Adult Mental Health Services and other interested stakeholders.[281]

5.4 The Youth Mental Health Commitments Committee

313. The YMHCC was established to progress work related to the government election commitment *Rebuilding intensive mental healthcare for young people*.[282]

314. The commitments include:

(a) the establishment of a new tier 3 facility;

(b) expanded day program services;

(c) reviewing AMYOS and Youth Resi services; and

(d) establishing additional youth residential services in Townsville.[283]

315. The YMHCC's function is to oversight planning for the implementation of new service options including:

(a) advice on site and service options;

(b) identifying priorities, objectives and costs; and

(c) consider funding, risks and opportunities, planning implications, evidence-based models of service, capital components and alternate options.[284]

316. The guiding principles for the YMHCC are:

(a) *Queensland Mental Health, Drug and Alcolohol Services Plan 2016-2021* (under development);

[281] See, for example, Breakey T6-42/L12-35; McDermott T7-56/L17-47; Sadler T17-47/L28 – T17-48/L21; Stathis T25-7/L15-33. Dr Kingswell indicated that much of this work may have already been undertaken by MHAODB – T13-57/L7 – T13-58/L13.
[282] Exhibit 282.
[283] Exhibit 253.
[284] Exhibit 282.

(b) Commission of Inquiry into the Barrett Adolescent Centre (to be developed);

(c) *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019*;

(d) *Hospital and Health Boards Act 2011*;

(e) *National Standards for Mental Health Services 2010*;

(f) *Financial Accountability Act 2009* and *Financial and Performance Management Standard 2009*;

(g) *Fourth Mental Health Plan*;

(h) *Mental Health Act 2000*; and

(i) National Mental Health Service Planning Framework.

317. The membership of the YMHCC is broad and includes a number of clinicians experienced in youth and adolescent mental health issues, as well as consumer and carer representatives.[285]

318. At the meeting of the YMHCC on 23 February 2016, an amendment was made to the Terms of Reference for the YMHCC to add the following considerations:

> *For the purpose of the committee planning, young people are considered to be from 13 to 18 years of age within the context of the proposed service models. However, the needs of young adults aged 18 to 24 with developmental issues will also be considered. and*
>
> *Considering patient flow and patient safety at transition points.*[286]

319. To date, the YMHCC has:

(a) commissioned and reviewed epidemiological data, which identifies the population of young people across Queensland, informing the location of future services;

(b) commenced evaluation of site options including by:

(i) considering and discussing:

[285] Exhibit 282.
[286] Exhibit 283.

(A) estimated capital costs;

(B) building timeframes;

(C) site location; and

(ii) identifying further considerations to be considered in due course such as:

(A) the recommendations of the COI;

(B) emerging evidence around partnership models for service delivery; and

(C) cultural considerations in the design process.

(c) reviewed and discussed literature, including:

(i) Mental Health Alcohol and Other Drugs Branch literature review;[287] and

(ii) the CHQ State-wide Sub-Acute Beds Discussion Paper dated January 2016;[288]

(d) identified immediate future considerations for the YMHCC, namely:

(i) developing different model of care options for pathways to treatment for young adults aged 18 to 24 with developmental issues; and

(ii) considering a summary of options to be developed by Mental Health, Alcohol and Other Drugs Branch.[289]

320. As was explained in the evidence of Associate Professor Stathis:

> *We're looking at a range of options, including the possibility of a 22-bed unit. We're also looking and costing up other options; for instance, potentially three seven-bed units, two units of, say, 10 beds each, where they might be. We're looking at mapping of services across the State in terms of population mapping.*

[287] QHD.031.001.0203 and QHD.031.001.0204 to .0214.
[288] Exhibit 280.
[289] Exhibit 283.

> *We're then going to undertake service mapping of where units or services should be across the state, and we're doing that in parallel and in anticipation of the Commission's findings so that a body of work would already be completed beforehand so that we can – so that any decisions in terms of future services may be expedited.*[290]

321. The population mapping conducted so far has involved consideration of a number of factors including age, service, diagnosis and geographic area.[291]

322. As is apparent from the evidence above, the YMHCC:

(a) is constituted by appropriately qualified experts;

(b) involves appropriate consultation across the state, including through the involvement of consumer and carer representatives; and

(c) has access to current data, including data that will enable the YMHCC to undertake necessary service mapping to ensure best placement of services where needs are identified and projected as ongoing.

323. It is also apparent from the Terms of Reference that any findings or recommendations of the COI will be fully considered before being included in future services for this group of young people.

324. The YMHCC is well placed to continue with the investigation of models of service delivery for sub-acute beds in Queensland, informed by the findings and recommendations of the COI.

5.5 Summary

325. Having regard to the evidence outlined above, the State respectfully submits:

(a) the AMHETI suite is a comprehensive and contemporary suite of services and is supported by the National Mental Health Services Planning Framework;

(b) there are potential gaps in the alignment of adolescent and adult services;

(c) there are potential gaps in the services available for dual diagnosis clients;

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[290] T25-5/L1-11.
[291] T25-5/L27-31.

(d) before articulating what services may be needed to address potential gaps, it would be appropriate to undertake a service mapping exercise;

(e) the AMHETI suite of services, which were supported by all psychiatrists, should continue to be progressed in a timely manner, with consideration given to the findings of the mapping exercise; and

(f) the YMHCC is well placed to continue with the investigation of models of service delivery for sub-acute beds in Queensland, informed by the findings and recommendations of the COI.

Elizabeth Wilson QC
Nicole Kefford
Janice Crawford
Counsel for State of Queensland
23 March 2016

Annexure A
Objections to Evidence

ANNEXURE A - OBJECTIONS TO EVIDENCE

Key

1	Hearsay
2	Outside Terms of Reference
3	Speculative/ Not Based on Fact
4	Outside Witness Scope of Knowledge

Patients, Family and Carers

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
	16		3, 4
	21		3
	13		3, 4
	30		3

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
	13		3
	15		1, 3
	24		3
	27		3
	10		3
	24		3
	35		3

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
	48		3, 4
	49		3
	25		4
	32		3
	33		3
	43		1, 3

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
	51		3, 4
	52		3, 4
	59		3
	62		3, 4
	64		3

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
	12		1
	25		4
	29		4
	26		3
	23		3
	13		3
	31		4

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
	33		3
	36		3
	26		3, 4
	42		3
	135		3, 4
	148		3, 4

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
	149		3, 4
	177		3
	19		3, 4
	35		3, 4
	44		3
	34		3
	36		3
	14		3, 4

Education Staff

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
Darren Bate WIT.900.006.0001	39	… because of how sick our students were. …	4
Stephan Marriott SMA.900.0001.0001	28	… They were students suffering mental health issues who were unable to attend mainstream schooling. …	3, 4
Stephan Marriott SMA.900.0002.0001	9	… The effects upon parents were also reported to me by other teaching staff and clinical staff. This included, but is not limited to: • parents ringing other teachers at the BAC School at Waco! asking if their adolescent could still attend after the Centre had closed; • the Principal reported to teaching staff that parents had been contacting the school wanting to discuss their worries over clinical matters. The Principal told the teaching staff that he had advised the parents that they would have to speak to health staff and parents stated that they were confused by the information; and • nursing staff reported in case conferences that parents were becoming angry that they felt they had not been given enough time or support to take their adolescent back into their care and were angry about the transition process. …	1

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
Stephan Marriott SMA.900.0002.0001	9	… The effects upon parents were also reported to me by other teaching staff and clinical staff. This included, but is not limited to: • parents ringing other teachers at the SAC School at Wacol asking if their adolescent could still attend after the Centre had closed; • the Principal reported to teaching staff that parents had been contacting the school wanting to discuss their worries over clinical matters. The Principal told the teaching staff that he had advised the parents that they would have to speak to health staff and parents stated that they were confused by the information; and • nursing staff reported in case conferences that parents were becoming angry that they felt they had not been given enough time or support to take their adolescent back into their care and were angry about transition process. …	1
Stephan Marriott SMA.900.0002.0001	12	… I believe the reduction in these services hampered the students' opportunity to find employment or go on to tertiary education. …	3
Stephan Marriott SMA.900.0002.0001	13	… The majority of students did suffer from a reduction in the Health Department services offered at BAC School at Tennyson, which were considerably less than the services offered when the BAC School was at Wacol.	4
Margaret Nightingale WIT.900.009.0001	60	… If students were discharged too early, their progress would deteriorate. … By the time they came to Barrett Adolescent Centre, their illnesses were chronic and severe. … …However, some illnesses would take years to treat and the students would get that treatment at the Barrett Adolescent Centre, which they were unlikely to get in the community service programs.	4

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
Margaret Nightingale WIT.900.009.0001	61	… I believe this happened as a result of the community service programs that were being set up. The community service programs would deal with adolescents with less severe mental illnesses. Only those with really severe illnesses, who had failed in the community services programs, would come to the Barrett Adolescent Centre. That resulted in students at the Barrett Adolescent Centre requiring longer admission periods than previously.	3, 4
Margaret Nightingale WIT.900.018.0001	9	… Their discomfort was related to their new location, and logistical changes, rather than the change in the teaching program itself.	3
Margaret Nightingale WIT.900.018.0001	44	… as the students felt unsafe….	3
Margaret Nightingale WIT.900.018.0001	47	… The discussions were about how, for the students, CYMHS had been unable to address the students' mental health needs and AMYOS was also not sufficient for them. The students had tried everything that was otherwise available and it had not helped them. We all knew how far off any new service would be in terms of being ready. …	3, 4
Margaret Nightingale WIT.900.018.0001	48	… not have the experience that those at the BAC had. …	3, 4
Margaret Nightingale WIT.900.018.0001	53	… Once the patients became accustomed to engaging with others at BAC, they were able to be integrated into their community.	3

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
Margaret Nightingale WIT.900.018.0001	56	… This is a very different experience to what occurred in adult wards.	4
Margaret Nightingale WIT.900.018.0001	60	… This is, in part, due to a correlation with the increase in the severity of the patients admitted to the BAC, but was also associated with the absence of a step-down model.	3, 4
Margaret Nightingale WIT.900.018.0001	61	A number of the patients could have been transitioned out of the BAC sooner had there not been such a large gap to the next available service.	3
Margaret Nightingale WIT.900.018.0001	72	… As for the allegations that the education staff were obstructionist, this filtered down from Peter Blatch to Kevin Rodgers from discussions he had had with management of West Moreton Hospital and Health Service.	1
Margaret Nightingale WIT.900.018.0001	87	… Apparently the parent body had previously expressed concerns about the commencement of a young mothers program at the Yeronga school. I was under the impression that the Yeronga school believed that if the parent body was not happy with the young mothers group, then they would not be happy with the co-location of the BAC special school.	1, 3

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
Margaret Nightingale WIT.900.018.0001	93	In my opinion, the optimal time frame for the closure would have involved: (a) time to have all of the recommended alternative services up and running prior to the commencement of transition; and (b) sufficient time to allow a gradual transition. This would be a flexible time frame. It may be six months for some patients, but even longer for others (up to 12 months). This lengthy period was particularly required considering there was no step-down facility.	4
Margaret Nightingale WIT.900.018.0001	94	… I got the impression that Dr Brennan did not have as much flexibility and independence in the process as she would have liked.	3
Margaret Nightingale WIT.900.018.0001	96	… However, I surmise that the delay was because the report was not what West Moreton Hospital and Health Service expected to get. I believe that the ECRG report was not what West Moreton Hospital and Health Service wanted to receive. I think it wanted to close the 8)1\C and that the ECRG report did not align with their plan so West Moreton Hospital and Health Service needed time to work out a strategy to close the BAC despite the contents of the ECRG report.	3
Margaret Nightingale WIT.900.018.0001	101	… This research, coupled with a strong culture of reflection, informed changes which ensured the provision of a contemporary service.	3
Justine Oxenham JOX.900.001.0001	21	… and most were then without educational support….	3

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
Justine Oxenham JOX.900.001.0001	29	… BAC demonstrated relationship based trauma informed model of care which I thought was excellent and appropriate. It was an inspiring model of care. The model required us to make the child feel safe, secure, and develop trust with us. We understood that the aberrant behaviours were caused by trauma and that medications affected learning. We tried to engage the students to enhance learning. The BAC model was highly regarded. …	4
Elayne Raisin WIT.900.022.0003	11	… As far as I was aware, [redacted] did not have a choice about this. …	3
Elayne Raisin WIT.900.022.0003	13	… However, one of the BAC nurses, Liam Huxter, told us that he spoke to [redacted] staff on the telephone, and they had told him that they did not want [redacted] to be involved because they did not think it would be appropriate for [redacted] at the time.	1
Elayne Raisin WIT.900.022.0003	29	The BAC School generally caters for students that no one else can cope with…	4
Deborah Rankin DRA.900.001.0001	15	… This is because special education training is not the best preparation for teaching adolescents with mental health concerns.	3, 4
Deborah Rankin DRA.900.001.0001	78	… After the announcement, Health staff members reduced all ongoing therapy with the students. Some students who were working through significant family traumas were without therapy for approximately six months and this undoubtedly had an effect on them.	3, 4
Deborah Rankin DRA.900.001.0001	79	… The casual health staff who replaced those permanent staff who moved on to other jobs did not have the necessary understanding of the students and their needs.	3, 4

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
Deborah Rankin DRA.900.001.0001	80	Those students whose trauma therapy had ceased and who had lost their individual therapists were most obviously suffering and other students who witnesses this suffering were also vicariously traumatised.	4
Deborah Rankin DRA.900.001.0001	120	… I feel that the Principal did this reluctantly. I think this because, at the meeting, Peter Blatch had to speak somewhat forcefully about the situation that we had nowhere else to go and we needed a facility….I felt it was a decision imposed upon the Principal by the Department out of necessity.	3
Deborah Rankin DRA.900.001.0001	145	… The young people with the most severe and chronic mental illness are caught up in a revolving door of admission to inpatient units and then back into the community with little change. Their families are running out of resources, financially and emotionally, and they struggle to survive with crisis care. The only interventions they have are mental health professionals.	3, 4
Deborah Rankin DRA.900.001.0001	147	However, balanced against the losses suffered since the closure of the BAC, there are some new students currently being supported by the School who would never have made it into admission at the BAC, but who need a service. An example of a student we have supported this year with less severe mental illness would be a	3, 4

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
Deborah Rankin DRA.900.001.0001	148		2, 3, 4
Deborah Rankin DRA.900.001.0001	149	These are students with high levels of anxiety who find it impossible to access education unless they have enormous adjustments, and schools have not been able to make these for them.	2, 3, 4
Deborah Rankin DRA.900.002.0001	66	Functional behavioural management is for children who have behavioural problems and require consistent unified processes. Such processes don't work with mental health students.	3, 4
Deborah Rankin DRA.900.002.0001	116	… I think Dr Sadler's extensive knowledge of potential alternative services for the patients would have been invaluable and that was lost when he was stood down.	4
Deborah Rankin DRA.900.002.0001	129	In my opinion Dr Brennan did not have as much experience as Dr Sadler and did not have as many relationships with alternative mental health providers. Accordingly, this lead to difficulties when she attempted to find alternative accommodations for patients.	3, 4

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
Deborah Rankin DRA.900.002.0001	130	A model similar to the BAC could assist those adolescents who are suffering from such severe and chronic mental health issues and who are unable to seek or receive assistance elsewhere.	3, 4
Deborah Rankin DRA.900.002.0001	143	… They had usually exhausted all other community, private or in-patient options.	3
Deborah Rankin DRA.900.002.0001	144	At Yeronga, cohort of students were those who did not have as severe and chronic mental health issues but they nevertheless must still have exhausted all community, private and in-patient options. …	3, 4
Deborah Rankin DRA.900.002.0001	148	Some of the students who attended the BAC School at Wacol would simply not be catered for at the School because of their high level mental health needs. They could only be supported by way of an out-reach program.	3, 4
Kevin Rodgers WIT.900.014.0001	86	The Barrett Adolescent Centre model at Wacol was an evidence based model that was successful. … …Though each of these facilities operates discretely to the work we were doing at the Barrett Centre, the programs were very similar and validated the work that occurred at The Barrett Centre	3, 4
Kevin Rodgers WIT.900.014.0001	96	The programs that were offered were evidence based and informed by the literature and information and expertise gathered from visits to similar programs interstate and overseas. …	3, 4
Kevin Rodgers WIT.900.014.0001	98	… I believe this was due to the supervision practices of the staff and their diligence in their duties.	3, 4

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
Megan Vizzard MVI.900.001.0001	37	Without BAC I consider the young people would just be lying in their beds all day ruminating about their problems, becoming more anxious and focussed on their issues, which in my opinion can lead to them having more thoughts of suicide and or self-harm.	3, 4
Megan Vizzard MVI.900.001.0001	40	In my opinion all of the young people at Wacol BAC, would have been success stories had Wacol BAC not been closed because they were really responding to, and benefiting from, the education and mental health assistance they received at the centre. I feel very sure of this. This is because in the 30 years of the operation of the Wacol BAC school, and during my involvement, I have never heard of a BAC student committing suicide until after it was closed.	3, 4
Megan Vizzard MVI.900.001.0001	59	… This led to more self-harming incidences that usually would not have been able to occur.	3, 4
Megan Vizzard MVI.900.001.0001	64	… I believe she was the person who told the young people that Dr Saddler was on holidays.	3
Megan Vizzard MVI.900.001.0001	70	… a parent I believe, informed the school that Sharon Kelly (from the Department of Health) said the Health staff wouldn't be doing a holiday program because they had never done one before or couldn't afford it (something to that effect). …	1
Megan Vizzard MVI.900.001.0001	73	After the decision to close the BAC was finally communicated to the young people, I consider all of the young people regressed.	4
Megan Vizzard MVI.900.001.0001	91		3, 4

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
Megan Vizzard MVI.900.001.0001	100	… I believe this was directly due to lack of clinical, mental health support. …	4
Megan Vizzard MVI.900.001.0001	123		1, 3
Megan Vizzard MVI.900.001.0001	129	I consider that there were clear signs that the transition process might place the students at an increased risk of suicide. Firstly, we knew that the students were not going into a replacement facility. Secondly, we knew that there was no way any other services out in the community would take care of these young people and keep them safe because that is what the purpose of BAC Wacol was. Thirdly, I consider that the transition plans were inadequate. Fourthly I gathered from the conversations that I was having with the young people that they were feeling distressed and anxious with the closure.	1, 3, 4
Megan Vizzard MVI.900.001.0001	130	I knew there were going to be suicides; I just strongly hoped that there wouldn't be.	3
Megan Vizzard MVI.900.001.0001	136	If the school closed down when Wacol BAC did I believe there would have been more suicides much quicker.	3
Megan Vizzard MVI.900.001.0001	138	While the school at Yeronga attempted to offer an appropriate level of education to the students however it was difficult to find appropriate mental health care as lots of the mental health transitional plans for the students fell through.	3

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
Megan Vizzard MVI.900.001.0001	141	The Education staff identified the insufficiencies in the transition plans for the young people (most of them had fallen through within 5 months).	3, 4
Megan Vizzard MVI.900.001.0001	150	… I believe this to be true for all the young people that were at the Wacol BAC at the time of the closure who were suicidal.	3, 4
Megan Vizzard MVI.900.001.0001	154	… however for the adolescence that didn't seem to be an option for them.	3
Megan Vizzard MVI.900.001.0001	159	One of the reasons that Wacol BAC was closed was that it was thought to be an 'out-dated' model, and that the Department of Health was moving towards a more contemporary service. This was inaccurate.	4
Megan Vizzard MVI.900.001.0001	160	People are still under the impression that Wacol BAC institutionalised the young people. This is also inaccurate as demonstrated by the activities that I have set out herein as well as the home visits the young people have.	4
Megan Vizzard MVI.900.002.0001	6	The transitions in 2013 were rushed and the young people could not get support from the people they knew from Barrett except the school once they knew the phone number. Some young people were very isolated; they went from having everything to nothing.	3, 4
Megan Vizzard MVI.900.002.0001	7	… In my opinion the young people in 2013 were not.	3, 4
Megan Vizzard MVI.900.002.0001	8	… these young people do not.	3, 4

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
Megan Vizzard MVI.900.002.0001	9	…and I believe it still is an appropriate model of care…	4
Megan Vizzard MVI.900.002.0001	14	In my opinion even if Barrett hadn't updated and changed is model over the years both clinically and educationally it would still be better than what was and is in the community now.	4
Megan Vizzard MVI.900.002.0001	36 (b)	… This resulted in the young people ending up without any services helping them, such as a psychiatrist/OT.	3
Megan Vizzard MVI.900.002.0001	37	… Suffice it to say there was a huge lack of mental health involvement with the young people.	4
Megan Vizzard MVI.900.002.0001	41	The model was extremely successful so there was no reason in my opinion for it to cease.	4
Megan Vizzard MVI.900.002.0001	44	…because those that could write them were too busy doing their jobs caring for the adolescence with not enough time to allocate undertakings such as writing papers.	3
Megan Vizzard MVI.900.002.0001	45	Everything we needed for those young people was located in those two buildings at Wacol. To have access to a similar standard of facilities and expertise now, the young people would have to go to a range of different locations, which in my opinion in no way would reach the standard of expertise we had at Wacol BAC. These young people cannot just go from service to service for the multifaceted support that they need especially those with anxiety.	3, 4

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
Janine Armitage DET.900.004.0001	6	… In my view all students at the Barrett School were classified as students with chronic and severe mental health issues, requiring a host of special needs interventions.	4
Janine Armitage DET.900.004.0001	28	… In my opinion, the services these students required were not always available where they lived. The Barrett Adolescent Centre supplied or provided a wraparound service of clinicians, allied health staff, nursing staff, therapists, and education that the students needed. My biggest concern was that this cohort of young people had such serious and complex mental health conditions that closing a wraparound service, in my opinion, was to leave them completely and utterly vulnerable. I believe that these young people need immediate access to clinicians, medical or allied health staff when an acute event occurs, and access to a longer term service to enable their recovery.	3, 4

Clinical Staff

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
Thomas Pettet DTP.900.002.0001	35	My impression was that no additional resources were available as, if additional human resources were introduced to these patients care, they would be viewed as a 'stranger' by the patients, and therefore potentially unwelcome.	3
Thomas Pettet DTP.900.002.0001	36	I had the impression that the current staffing could not be expanded and that we had to continue with the current level of resourcing.	3
Thomas Pettet DTP.900.002.0001	39	… I felt it would be unlikely that any extra human resources would be available, and we anticipated that the workload would steadily decrease anyway.	3

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
Carol Hughes WMS.9000.0017.00001	6.2	Because my background includes Bachelor of Business Public Administration, I also privately assumed that BAC was very expensive to operate that that there were no funds available in the next financial year for BAC to continue to operate.	3
Georgia Watkins-Allen GWA.001.002.0001	63		3
Georgia Watkins-Allen GWA.001.002.0001	74	… had there been adequate care elsewhere, they would have already been transitioned there or in the process of being transitioned there….	3
Matthew Beswick DTP.900.002.0001	15(c)	...If someone can make a decision to remove at this crucial juncture it is difficult to believe that the patients' best interests were behind decisions that are coming "from above".	3
Matthew Beswick DTP.900.002.0001	20(a)(ii)	… I recall that transition staff had to make difficult decisions based on the sub-optimal choices available to them when choosing transition arrangements. …	3
Matthew Beswick DTP.900.002.0001	22(c)(i)	My understanding is that the process was difficult due to the sub-optimal choices having to be made. Therefore, dates were changed to allow some more time.	3
Matthew Beswick DTP.900.002.0001	24(b)(i)	…It was common knowledge that the transition decisions were made with sub-optimal choices available. I believe the team knew they were making the best choices from a range of sub-optimal choices.	3, 4

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
Susan Daniel QNU.001.004.0038	13(a)(iii)(1)	I considered Dr Sadler to be a major player and influential in the Expert Clinical Reference Group which was looking at alternatives to the BAC. It seemed to me that once Dr Sadler was out of the way, the interest in an alternative unit seemed to take a back seat to unit closure.	3
Susan Daniel QNU.001.004.0038	13(b)(i) (4)	I do recall that Dr Sadler was hopeful that the unit would transition to another location which, I understand, was raised by him at the Expert Clinical Reference Group meetings. Because of this, his approach to transition may have been different.	3
Padraig McGrath WMS.9000.0012.00001	16.9	(a) Transition plans would have taken into account: (i) the clinical history and current condition of the patient; (ii) the patient's wishes in respect of matters such as what treatment the patient was willing to receive, where the patient wished to reside and their intention/aspirations in respect of study, employment etc; and (iii) information from the patient's family or carer regarding family support and the wishes of the family with respect to where the patient would live, treatment options etc. (b) Consideration would have been given to the alternative services available in other HHSs or through non-government providers to meet the patient's clinical and other needs. (c) Transition planning included processes to link the patient to the new services to which they were being transitioned, including introducing the patient into the new services and providing the patient with information about accessing services. (d) Considerations which informed the transition plans included ascertaining from	3

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
		both the patient and their family how comfortable they were with the transition process, where the patient wanted to live in the future, aspirations with respect to study etc and the treatment options relevant to the patient's needs and which of those services the patient was willing to accept.	
Rosengela Richardson QNU.001.003.0001	36(a)	… it sent a message to the staff that Queensland Health did not think these patients were important enough.	3
Victoria Young QNU.001.005.0001	30(e)	The nursing staff were concerned about the patients and felt powerless to really help them.	1, 3
Cary Breakey WIT.900.002.0001	42(a)	There is no more contemporary model that is effective in treating this group of adolescents. By the time patients reached BAC, almost all had recurrent failed admissions to acute units.	3

Additional Objections

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
	7		1
	22		3

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
	30		3
	34		3
	36		4
	41		4
	41		4

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
	43		3,4
	57		3,4
	62		3,4
	64		3,4

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
	65		3,4
	6		3
	6		1
	16		1
	16		3, 4

Witness Statement/ Doc No.	*Paragraph Number*	*Objectionable Material*	*Objection Taken*
	16		3, 4
	17		3
	18		3, 4
	19		1, 3
	27		3

Annexure B
Objections to Counsel Assisting's closing submissions

Paragraph Number	*Objectionable Material*	*Objection Taken*
6	… almost certainly, mostly new staff	Submission not open on the evidence.
11	… There seemed to be little emphasis on ensuring that the decision is the correct decision or the best decision and is supported by proper and detailed analysis. The result is that the decisions made in this case appear to be based, not on any sound factual foundation, but rather on the unstable foundations of unattributed conversations and abbreviated or shorthand expressions. The expression "*contemporary models of care*" is an example.	Proposition not put to relevant witnesses.
91	… who did not fit into disability services.	Proposition not put to relevant witnesses. Submission is not open on the evidence.
114	… it is difficult to imagine any child and adolescent psychiatrist referring to a subacute patient to the acute ward.	Submission not open on the evidence.
120	… And so, not surprisingly, the decision was made in a fragmented way, with no proper analysis, and for disparate reasons based on unsafe factual foundations.	Proposition not put to relevant witnesses. Submission not open on the evidence.
174	… That was presumably because the WM HHB had not sought a removal of the BAC through an Amendment Deed, as required by the WM Agreement.	Proposition not put to relevant witnesses
176	Nevertheless, the lack of clarity about the legal responsibility for the decision seems to have translated to a lack of any rational process in the decision-making.	Proposition not put to relevant witnesses. Submission not open on the evidence.

Paragraph Number	***Objectionable Material***	***Objection Taken***
184	The briefing note is remarkable not for its content but for the lack of supporting reports or information. … And yet the decision to cancel that decision is said to have been made with no support from experts and no identifiable '*sector consultation*'.	Proposition not put to relevant witnesses. Submission not open on the evidence. Irresponsible, having regard to the evidence.
185	That Dr Kingswell, Dr Geppert and Dr Young were confident enough to put such a proposition to Dr O'Connell in the absence of supporting information and expertise is surprising.	Proposition not put to relevant witnesses. Submission not open on the evidence. Irresponsible, having regard to the evidence.
188	That original expert advice was in effect disregarded …Each of those 3 reasons is unsupported in the sense that no direct information was obtained from Professor Crompton and his team.	Proposition not put to relevant witnesses. Submission not open on the evidence. Irresponsible, having regard to the evidence.
192(c)	The theory is raised as a slogan without any specific detail (what aspect of the model is not contemporary and why?)	Proposition not put to relevant witnesses. Submission not open on the evidence.
194	… On that basis, it is odd to use that draft as evidence that a particular service is no longer contemporary and to do so without seeking the advice of a child and adolescent psychiatrist.	Proposition not put to relevant witnesses. Submission not open on the evidence.
195	… Nevetheless, it may have been an influence.	Proposition not put to relevant witnesses. Submission not open on the evidence.
196	The result is a decision that seems some distance from both a factual foundation and proper expert advice.	Proposition not put to relevant witnesses. Submission not open on the evidence.

Paragraph Number	***Objectionable Material***	***Objection Taken***
203	But, the problems with the decision are these: (a) there were no documents or reports or advice which recorded the advice to the Minister that the Redlands project was "*not the appropriate model of care and the project should be ceased*"; (b) there were no documents or reports which addressed the consequences of the decision to cancel 3 projects and defer a 4th project; (c) that must have made it difficult to perform a balancing exercise which assessed the competing demands for the $41 million in taxpayers money;	Proposition not put to relevant witnesses. Submission not open on the evidence.
204	On the evidence the likelihood is that this was a political decision, made by the Minister without any analysis or balancing of competing demands. Further, the likelihood is that the Minister made the decision without any advice from Queensland Health and without consideration of the consequences of the 4 cancelled or deferred projects.	Proposition not put to relevant witnesses. Submission not open on the evidence.
205	… But it is more than a little surprising that the decision is not supported by any reports, or analysis, or detailed consultation and that there is not a hint of advice or caution from the department, let alone from Dr Kingswell or Dr Young.	Proposition not put to relevant witnesses. Submission not open on the evidence.
207(a)	In fact, the Planning Group does not appear to have formally met to consider the ECRG Report	Proposition not put to relevant witnesses.
209	There is no evidence of any debate or consideration by the board of the content of the Agenda Paper. … There is no evidence that any board member asked what the barriers were and why they could not be resolved. Presumably, those statements were accepted.	Proposition not put to relevant witnesses.
210	Of course, the statement of fact that Redlands had ceased because of "*unresolvable building and environmental barriers*" is not supported by any evidence.	Submission not open on the evidence.
211	… there is no evidence of any debate about it by the board.	Proposition not put to relevant witnesses.

Paragraph Number	***Objectionable Material***	***Objection Taken***
214	There is no evidence that Dr Corbett and Mr Eltham properly read or noted the views of the ECRG. … And yet, neither board member appears to have recognised that at the time.	Proposition not put to relevant witnesses.
215	… In fact, there is no Planning Group report *per se*, let alone any analysis by that group. Rather, the Planning Group made comments in the right hand column of the ECRG Report.	Submission not open on the evidence.
216	In the circumstances, the board's decision to proceed with the closure of the BAC is inexplicable. Also inexplicable is the apparent lack of scrutiny or debate.	Proposition not put to relevant witnesses.
220	… superficial …	Proposition not put to relevant witnesses. Submission not open on the evidence.
231	… which lack any factual foundation …	Proposition not put to relevant witnesses. Submission not open on the evidence.
258	The fourth is the complete absence of any considerations of the views of the ECRG.	Proposition not put to relevant witnesses.
259	And the fifth is that, as explained above, the decision appears to be based on an Agenda Paper that was not scrutinised and was plainly inaccurate or misleading.	Proposition not put to relevant witnesses.
261	In short, the board's decision is a superficial one – probably based on the presentation of Ms Kelly and Ms Dwyer and on an agenda paper which was inaccurate or misleading.	Proposition not put to relevant witnesses. Submission not open on the evidence.
262	… the likelihood was that they would cease to receive funding for it. …	Proposition not put to relevant witnesses. Submission not open on the evidence.

Paragraph Number	*Objectionable Material*	*Objection Taken*
268	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.	This suite of propositions was not put to relevant witnesses. Submission not open on the evidence.
394	Little, if any, weight ought be afforded Associate Professor Kotze's evidence on this point. It is highly speculative and general.	Proposition not put to relevant witnesses. Submission not open on the evidence.
455	While it is not the role of the Commission to determine a causal link between any deficiencies in the management of this risk and any critical incident that occurred before the development and rollout of service options …	These words should be struck out. The submission is beyond the terms of reference with no evidential basis.
491		Not relevant to the terms of reference.
492		Not relevant to the terms of reference.
493		Not relevant to the terms of reference.
724	Relevantly, prior to this in July 2012, Ms Kelly had directed staff not to make any recordings of formal or informal meetings with colleagues or management.	Irrelevant to the Terms of Reference.

It is also noted that paragraphs 809 to 813 contain personal information of staff that should be treated confidentially.

Annexure C
Closure decision -
Chronology of key events

Date	Event	Reference
15/01/2009	Minister for Health approves brief for the acquisition of land at Weippin St (Lot 30) for the expansion of Mental Health services from the Redland Hospital, the expansion of other hospital services in the future and the relocation of the BAC from Wacol.	QHD.004.014.4197
March 2009	Report on the Site Selection for Adolescent Extended Treatment Unit recommends relocation to Redland Hospital.	QHD.004.004.7525
31/08/2009	Briefing note to Minister of Health regarding the relocation of the BAC to Redland Hospital.	Exhibit 238 QHD.007.001.1959
24/01/2012	Draft Briefing Note for DG (Dr Tony O'Connell) advising the DG of delays to the Redland Adolescent Unit project marked as "NFA". Contains handwritten notes (believed to be Director Mental Health, Dr Aaron Groves) advising "*CDP can not to go to tender as pre-tender estimate 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*".	Exhibit 226 QHD.004.014.8371
16/05/2012	Briefing Note for Approval of DG (Dr Tony O'Connell) to cease the Redlands Adolescent Extended Treatment Unit Capital Program, as requested by Chief Health Officer (Dr Jeannette Young). Briefing Note is authored by MHAODB.	DDK.001.001.0032

Date	Event	Reference
28/06/2012	Service Agreement between Queensland Health and West Moreton HHS executed covering the period between 1 July 2012 to 30 June 2013 – including delivery of the *Adolescent Extended Treatment and Rehabilitation Centre (state-wide)*.	Exhibit 228 WMS.1007.0484.00021
1/07/2012	Commencement of the *Hospital and Health Boards Act 2011* (Qld)	
28/08/2012	Minister for Health (The Honourable Lawrence Springborg) approves the cessation of the replacement Adolescent Extended Treatment Unit at Redlands as one of the deferred/cancelled projects to fund the rural infrastructure rectifications.	QHD.006.005.2343
25/10/2012	Meeting between Sharon Kelly (Executive Director of Mental Health and Specialised Services, West Moreton HHS) and MHAODB for confidential briefing and concept development regarding closure of BAC.	Exhibit 66 WMS.0011.0001.19338 (SK-9)
8/11/2012	Dr Brett McDermott (Executive Director of Mater Child and Youth Mental Health Service) informs the Queensland Child Protection Commission of Inquiry about the closure of BAC.	Exhibit 84 PBM.001.002.001 at .0017
16/11/2012	Commencement of Barrett Adolescent Strategy as per the Strategy Project Plan – establishment of the Barrett Adolescent Strategy Planning Group and ECRG. Project Plan tabled by Lesley Dwyer (Chief Executive, West Moreton HHS) at the meeting of the West Moreton HHS Board on 23/11/21012.	Exhibit 214 WMS.0012.0001.14639 Exhibit 41 WMB.9000.0001.00125 (MC-15)
14/12/2012	Minister for Health briefed by Dr Mary Corbett (Chair, West Moreton HHS Board), Lesley Dwyer and Sharon Kelly.	Exhibit 41 WMB.9000.0001.00069 (MC-05)

Date	Event	Reference
08/05/2013	ECRG endorsed recommendations submitted to the Planning Group.	Exhibit 216 WMS.1000.0045.00014
24/05/2013	West Moreton HHS Board considered the recommendations of the ECRG and Planning Group comments and approved the closure of the BAC dependent on alternative, appropriate care provisions for the adolescent target group and the meeting with the Minister for Health.	Exhibit 41 WMB.9000.0001.00146 (MC-19) WMB.9000.0001.00169 (MC-20)
20/06/2013	Further service agreement between Queensland Health and West Moreton executed covering the period 1 July 2013 to 30 June 2016 – including delivery of the *Adolescent Extended Treatment and Rehabilitation Centre (state-wide)*.	Exhibit 182 LJS.002.0001.0014
08/07/2013	Briefing Note for Noting to Minister for Health regarding decision of West Moreton HHS Board on 24 May 2013.	QHD.008.001.3858
15/07/2013	Minister for Health briefed by Dr Mary Corbett and Ms Lesley Dwyer.	Exhibit 49 WMS.9000.0010.00001 at .00014
06/08/2013	Minister for Health announces closure of BAC.	
22/10/2103	Memorandum from Sharon Kelly to Executive Directors and Clinical Directors of Mental Health Services regarding admissions to BAC.	Exhibit 284 WMS.1007.0038.00001
12/12/2013	Briefing Note for Noting to the DG (Ian Maynard) and Minister for Health regarding flexible closure date of January 2014 (dependent on consumers having appropriate transition plans in place and continuity of service delivery).	Exhibit 231 QHD.006.005.1169

Date	Event	Reference
30/01/2014	Service Agreement between Queensland Health and Children's Health Queensland HHS amended to include delivery of specific programs including the *State Wide Adolescent Extended Treatment and Rehabilitation (AETR) Implementation Strategy*.	Exhibit 245 LJS.002.0001.0001
31/01/2014	Closure of BAC.	
August 2014	West Moreton Service Agreement 2013/14 – 2015/16 amended by Deed of Amendment July 2014 removing delivery of the *Adolescent Extended Treatment and Rehabilitation Centre (state-wide)*.	Exhibit 183 LJS.002.0001.0062