(c) [redacted]

(d) I attended the Parent and Carer Information Session on 10 December 2013 as described above.

(e) In the context of Dr Sadler being temporarily stood down and at the request of Sharon Kelly, I and Dr Darren Neillie, who was Acting Clinical Director of The Park while Dr Terry Stedman was on leave, between us attempted to telephone the parent/carer representatives of then BAC patients to advise them of the situation. Not all calls were answered in the first instance and Sharon Kelly arranged follow up for those that were not successfully contacted that night.

(f) [redacted]

(g) I had several telephone conversations with the [redacted] of another patient, who also had regular contact with Sharon Kelly and Lesley Dwyer in the period after the closure announcement was made, when I was acting in Sharon Kelly's role during a period she was away. This contact was mostly about [redacted] adolescent's service options post closure, which were under active consideration at that time by the clinical team. [redacted] also raised concerns about ongoing communication processes with BAC parents/carers. I discussed [redacted] concerns with [redacted] and gave feedback to Lesley Dwyer regarding possible options for responding to these concerns.

(h) I had occasional contact with parents who rang with concerns of a generic nature such as that transition of their adolescent was not happening quickly enough or that they wanted more support than they felt was being offered. This sort of contact was usually made by parents to Dr Brennan or Sharon Kelly, but occasionally I received a call of that kind.

(b) What involvement did Dr Geppert have in developing and implementing the WMHHS "communication strategy" with parents and carers of BAC patients?

10.3 I was not directly involved in the development of the original WMHHS communication strategy, which was developed before I commenced my secondment at WMHHS. However, I did contribute to communication strategy revisions post my commencement with WMHHS. The communication strategy was predominantly the responsibility of Communications and Media staff within WMHHS, with input from all key stakeholders of the BAC Strategy.

10.4 In terms of implementation of the strategy, I was not responsible for individual communications with parents and carers save for those described above. I was involved in developing key messages for stakeholders and the preparation of generic written materials. For example, the Fast Facts sheets were typically prepared by the Communications and Media team and Laura Johnson, with input from myself, and were then signed off by Sharon Kelly. My role was to ensure that the communications were consistent and the content was appropriate and accurate.

(c) What was Dr Geppert's role in addressing the concerns of families of BAC?

10.5 I did not have a formal identified role in addressing the concerns of families of BAC patients. My involvement in that regard is described above.

11 What involvement did Dr Geppert have in developing, managing and implementing the transition plans for the BAC patients (including, but not limited to identifying, assessing and planning for care, support, service quality and safety risks)?

(a) Who was Dr Geppert accountable to and responsible for when she was discharging these responsibilities?

11.1 I was responsible to Sharon Kelly, as my line manager, in all of my work duties.

11.2 I had no oversight of or responsibility for preparing clinical transition plans for the BAC patients.

11.3 I did not have any clinical role in the assessment of BAC patients nor was I involved in determining the transition plan for any particular patient from a clinical perspective. I was not responsible for quality and safety issues from a clinical perspective.

11.4 My involvement with respect to developing, managing and implementing transition plans for BAC patients was that:

(a) I was a key contact for internal and external stakeholders to WMHHS regarding the progression of transition plans, and was specifically involved in supporting the development of and then referring funding requests to the appropriate decision-maker regarding transition packages.

(b) I was engaged in the development of solutions and negotiations with key stakeholders when barriers were identified with the implementation of transition plans.

(c) I was the person to whom matters were escalated if Dr Brennan was experiencing barriers to progressing a particular transition plan through normal referral processes, and for transitions that required additional funding (in addition to care already provided through the public system). From my previous role as Director, Planning and Partnerships MHAODB I had detailed knowledge of the funding system and I knew to whom and how a funding request should be made. I knew contacts within the other HHSs from whom to obtain information about required services and the cost of those services and I had the knowledge to support the preparation of funding submissions. Some receiving HHS services sought my advice in this regard, while others did not. Accordingly, my role was that I received information from Dr Brennan as to the clinical needs of the patient and required services, I was able to obtain (or coordinate others to obtain) the necessary information from the provider regarding cost and I would then work with the receiving HHS service to prepare the funding

submission, or advise them as to how the funding submission should be structured, and submit the funding submission to MHAODB for approval.

(d)

(b) What were the key challenges m the development, management and implementation of the BAC transition plans?

11.5 Dr Anne Brennan, with the assistance of the transition team, had the principal role in developing, managing and implementing BAC transition plans. I was not involved in any clinical capacity.

11.6 In terms of my involvement, the key challenges were:

(a) There was a need to negotiate individual funding packages for the care of a number of BAC transition patients. The majority of these were arranged without any significant complications. In a small number of cases, there was a need to negotiate more intensely with a receiving HHS/other care provider as to the level of support required for a patient. One case required escalation to the Director-General of Health, seeking support from another government agency to more actively engage in the transition plan for a BAC patient.

(b) Except for the one case mentioned in 11.4(d) above, I do not recall any matter in which funding was not ultimately agreed on a basis that was satisfactory to the receiving HHS and covered the transition arrangements which Dr Brennan and her team had determined were appropriate for the particular patient.

(c) My understanding is that most of the parents and carers of BAC patients were comfortable with the transition arrangements being recommended by the transition team. I was aware from Dr Brennan that a small number of parents were anxious and/or negative about the arrangements being recommended for their adolescent and required a higher level of engagement in order to be reassured that the transition arrangement was appropriate for their adolescent.

(c) What involvement (if any) did Dr Geppert have in ensuring that the educational needs of BAC patients were considered in the development, management and implementation of their clinical transition plans?

11.7 I had no direct involvement in ensuring that the educational needs of BAC patients were considered in the development, management and implementation of their clinical transition plans.

12 Explain how Dr Geppert worked with Dr Brennan and Dr Stathis in relation to the transition of BAC patients.

12.1 My work with Dr Brennan in relation to the transition of BAC patients was:

(a) I had no responsibility for the clinical assessment or decision-making in relation to BAC patients or their individual transition plans. At times, I provided strategic advice to Dr Brennan about the most appropriate contacts in various services associated with transition, and suggested processes to engage these contacts or made the contact on behalf of Dr Brennan.

(b) I had no clinical oversight role in respect of Dr Brennan or other clinical team members of BAC.

(c) Where Dr Brennan identified barriers to ordinary transition for a patient, or that a patient had special needs over and above what would be required in an ordinary transition situation, the transition arrangement typically required additional funding support. As outlined above, I was involved in negotiating funding packages.

(d) I attended the BAC Weekly Update Meeting, which was also attended by Dr Brennan. The transition of BAC patients was discussed at those meetings from the perspective of discussing the progress of transitions, any identified barriers or difficulties with transition and necessary actions to overcome any barriers or difficulties. There was a risk mitigation focus and an issues register was maintained, which was updated on an ad hoc basis.

12.2 To the best of my knowledge Dr Stathis had no direct involvement in the clinical transition plans for BAC patients. I copied Dr Stathis into emails regarding the funding for additional services where necessary for individual transition patients because those funds would come from MHAODB from funds designated for release to CHQHHS upon CHQHHS taking over adolescent extended treatment services.

13 What arrangements were made for adolescents on the BAC waiting list who would otherwise have been admitted to the BAC? What involvement (if any) did Dr Geppert have in making these arrangements?

13.1 Kathy Stapley, a State-wide social work professional lead for mental health based at WMHHS was asked to review the wait list, in consultation with Dr Anne Brennan.

13.2 One or other of them would then go back to the referring service provider to discuss the wait listed patients' current status. As BAC was no longer a service option, it would have been a matter for the referring provider to determine other avenues for care of the wait list patient. Dr Stephen Stathis was also engaged in this process, given that CHQHHS held state-wide governance for child and adolescent mental health service options post BAC closure.

13.3 Although I was not directly involved in conducting the actions of this process, my understanding from Kathy Stapley and Dr Anne Brennan is that:

(a) A number of patients on the wait list had, in the period since referral to BAC, been discharged from care by the referring provider agency.

(b) In the case of those who were still receiving and requiring care, the discussions with the referring providers resulted in an appropriate plan of care.

(c) To the best of my knowledge, there were no cases where the referring provider expressed a view that, with the closure of BAC, there were no other acceptable options for the wait listed patient.

14 We understand that Dr Geppert was a member of the State-wide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Steering Committee.

(a) Explain the purpose and role of this Committee, and how this Committee was involved in decisions relating to the BAC transition process.

14.1 The purpose and role of the SWAETRI is contained in its terms of reference, a copy of which is attached LG-9.

14.2 The committee was not involved in individual clinical decisions relating to the BAC transition process. It received a regular report from WMHHS as to the status of transitions, but had no role in, or oversight in respect of, the clinical transition process for individuals. All transitions were developed by the relevant members of the clinical team at WMHHS on an individual basis for the patient.

14.3 Noting the SWAETRI reported to the CE and Department of Health Oversight Committee, the SWAETRI received monthly updates from Dr Brennan, that provided a de identified update on the transition planning process, issues faced in the implementation of transition, and associated risks.

(b) We understand that the Steering Committee invited the families of BAC patients to make submissions in relation to the development of service options. How were these submissions considered, evaluated and incorporated in this process?

14.4 The SWAETRI and Lesley Dwyer invited families of BAC patients to make submissions in relation to their experience and perspectives as carers. Additionally the aim was to offer an opportunity for the parents to directly engage with the SWAETRI and have input into the consideration for future service options. For that purpose, representatives of families attended a meeting of the committee on 4 November 2013. Attached and marked **LG-18** is a copy of the submission put forward by the families at that meeting.

14.5 These submissions were considered and evaluated by the SWAETRI in session following the parents' presentation, and members were invited to consider out of session the written materials which the parents had left for the SWAETRI members.

14.6 Many of the service options mentioned in the parents' submission, such as mobile services, were either already in planning or were under active consideration by SWAETRI. Others, such as the submission regarding the advantage of having a school on site, had been thoroughly considered in a range of forums prior to this meeting. The parents' submission did not raise new matters for consideration in respect of that option. The submission suggested there were some benefits to the provision of services away from the family and community in which the adolescent ordinarily lived, which the Committee considered contrary to the national and State objectives of providing treatment locally where possible and engaging the family in the young person's life.

14.7 As a committee, we were not confident that the presentation necessarily represented the views of the broader parent community. As an example, the view expressed regarding the benefits of a young person being treated as an in-patient away from the home environment for long periods of time was not a view I had encountered amongst a majority of parents during my years of clinical practice nor was it a view expressed by clinician representatives on the SWAETRI.

15 We understand that Dr Geppert was part of the Young Person Extended Treatment and Rehabilitation Initiative Governance Panel/Committee, which met weekly from November 2013. Explain the purpose and role of this Panel/Committee, and how this Panel/Committee was involved in decisions relating to the BAC transition process.

15.1 I was a part of the Young Persons Extended Treatment And Rehabilitation Initiative (**YPETRI**) Governance Committee.

15.2 The purpose and role of this committee is as set out in the Terms of Reference for the committee, a copy of which is attached as **LG-19**.

15.3 The YPETRI had no involvement in decisions relating to the individual transition processes of BAC patients. Its purpose was to provide strategic, clinical and operational governance to the development and implementation of the WMHHS, CHQHHS and Aftercare transition service options, that had been delineated via the SWAETRI. One of the key deliverables was the establishment of the adolescent residential program, to be delivered as a pilot program initially for 12 months by Aftercare.

15.4 The Adolescent Residential has capacity for five patients staying for up to 12 months. The model of care has been shaped over time, but commenced under the following principles:

(a) Non-clinical rehabilitation services and life skills are provided at the residential in a type of day program structure by Aftercare, a non-government organisation funded to provide that expertise.

(b) Clinical mental health needs are provided in the same manner as for other mental health patients residing in the community. This would differ according to each young person's needs but as an example could include outpatient care via the local CYMHS.

(c) Educational needs are provided through mainstream schooling in the community setting.

15.5 [redacted]

15.6 [redacted]

16 We understand that Dr Geppert was involved in sourcing funding packages and engaging in high level negotiations with other departmental agencies to facilitate housing and disability support in addition to the care provided through mental health services.

(a) Which BAC patients did Dr Geppert source these funding packages for?

16.1 I was involved with sourcing funding packages for BAC patients, being patients and . The primary source of funding was provided through the MHAODB for requests associated with the provision of care through to the end of the 2013/14 financial year. This was because the funding cycle runs on a financial year cycle. It was understood that further requests for funding could be requested for care beyond that period if necessary. MHAODB indicated that the operational funding previously allocated to the ceased Redlands capital project (approximately $2,000,000) would be redirected to the transition packages. It is my understanding that this recurrent operational funding of $2,000,000 would then be transferred from MHAODB to CHQHHS from 2014/15 onwards for their utilisation against adolescent mental health services.

(b) What type of services were provided under these funding packages?

16.2 The types of services which were provided under these funding packages were:

(a)

(b) [redacted]

(c) [redacted]

(d) [redacted]

(e) [redacted]

(f) [redacted]

(c) Why were these funding packages required for these patients?

16.3 Funding packages were required for these patients because it was agreed by MHAODB and WMHHS that they would take responsibility for the financial implications of transferring a BAC patient to another facility in the context of BAC closing, i.e.:

(a) At the time closure of BAC was announced, there were several patients already in the process of being discharged. Their discharge was not in consequence of the decision to close BAC, as they would have been discharged from BAC in any event due to readiness regarding their clinical situation. For those patients, no funding packages were necessary as the patients were transferred to the same care they would have received irrespective of BAC closing or remaining open.

(b) For patients who were transitioned because BAC was being closed, funding packages were available to cover aspects of care of the BAC patient which would be over and above that which the patient would ordinarily receive as a routine admission to that receiving facility or service.

(c) For some patients being discharged from BAC into community care arrangements or following discharge from an acute in-patient admission after BAC, there was a cost with respect to accommodation as the patient was no longer in a residential facility and had no family or other suitable accommodation option. Funding was provided to

non-government organisations for the provision of accommodation, as well as for individual programs of care around rehabilitation in a community context.

(d) Who was responsible for deciding whether or not to grant requests for additional funding, and how were these requests evaluated?

16.4 MHAODB was ultimately responsible for deciding whether or not to grant requests for additional funding as they held the funds for that purpose in 2013/14.

16.5 The process was that Dr Brennan and the clinical team would identify whether the patient required care over and above what the patient could expect to receive in the public system, or in some cases, the receiving services themselves identified this need. If additional care was considered necessary, I would request that the receiving services for that care liaise with Dr Brennan regarding clinical needs, and that they submit a funding request for any additional services to me. I would ensure all decision-makers in WMHHS, MHAODB and CHQHHS had the opportunity to consider the individual case, and with this information, MHAODB would decide whether to approve the request.

16.6 MHAODB did not question the clinical assessment of the patients' needs, but on some occasions MHAODB and/or CHQHHS and/or WMHHS would question whether there were alternative ways of providing the same care under a different costing structure or funding source (for example, application for a Housing and Support Package for a patient). In those cases, it was a matter of discussion and agreement.

17 We understand that the BAC operational funding was transferred to CHQHHS and all related expenditure had to be approved by both CHQHHS and WMHHS. Explain how this funding was applied and what involvement Dr Geppert had in relation to making decisions about the application of this funding.

17.1 BAC had an operating budget for the 2013/14 financial year. WMHHS was no longer entitled to that funding once BAC actually closed. Accordingly, the position was that, upon the closure of BAC the remainder of the operational funding for the 2013/14 financial year was transferred to CHQHHS as the agency holding governance for adolescent mental health services from that point in time. It was my understanding that this funding was

recurrently transferred, and utilised to fund new and expanded adolescent mental health services developed through the SWAETRI and YPETRI committees.

17.2 Ahead of the closure of BAC, it was not the case that expenditure had to be formally approved by both CHQHHS and WMHHS. Expenditure against the BAC operational budget was the ultimate responsibility of WMHHS until BAC closure, but it was agreed in a meeting 12 December 2013 that both HHSs would consider the impact of any subsequent expenditure on the remaining BAC operational budget.

17.3 From time to time between the announcement of the closure of BAC and the actual closure, CHQHHS would ask for information as to how much of the annual operating budget was left. This was a reasonable information request, given that CHQHHS would be responsible for provision of services once BAC closed and they therefore needed to be clear about how much funding was being transferred and at what time. If there were major cost items being contemplated in that period, WMHHS usually informed CHQHHS of this as a matter of courtesy and for their planning purposes, but again it was my understanding CHQHHS had no direct authority to veto such expenditure.

18 We understand that an initial BAC closure date of 26 January 2014 was communicated internally, but later changed to the end of January 2014.

(a) Who was involved in making decisions in relation to the closure date of the BAC?

18.1 I have no recollection that there was ever an initial BAC closure date of 26 January 2014, nor any formal decision that this was changed to the end of January 2014.

18.2 The December 2013/January 2014 school vacation period was identified as the target period within which to complete the transition of BAC patients, however there was never a rigidly fixed closure date. The closure of BAC was always dependent upon the completion of safe and appropriate transition of all patients to other services.

18.3 In that regard, the decision in relation to the closure date of BAC was determined by the clinical needs of an effective transition of each patient, not by any one individual independently specifying a closure date for BAC. I note that other variables associated

with the issue of safe and effective clinical transitions of patients were considered in deliberations regarding the closure date, such as:

(a) The end of school terms (so as to limit the disruption to patient schooling needs) and

(b) The milieu of the BAC inpatient unit. For example, concern was raised by clinical staff in December 2013 that a small group of two or three adolescent inpatients remaining in BAC would not be a healthy environment to continue providing treatment in.

(b) Did the communicated closure date affect the transition planning process, and if so, how?

18.4 Having an established objective of transitioning patients over the December 2013/January 2014 vacation period established a context to work towards with respect to transition planning. I am not aware of any respect in which this directly dictated or altered the transition planning for any individual patient. Transition of patients was, in each case, primarily dictated by clinical considerations as to the best interests of the patient and it was clear that even the identified date of end of January 2014 could be reconsidered if there was no suitable transition option for one or more of the patients.

(c) Did any stakeholder seek to renegotiate this date on the basis of clinical necessity? If so, how were these concerns managed and addressed?

18.5 I am not aware of any stakeholder seeking to renegotiate the closure date. The aim of closure by end of January 2014 was well publicised and I am aware that some parents/carers were anxious as to whether their adolescent could be safely and effectively transitioned to another service within that timeframe. I do not recall any parent specifically seeking to renegotiate to have their adolescent stay at the BAC beyond January 2014. I was not involved in direct communications with parents and carers to any great extent, but my understanding is that they were assured that transition of their adolescent would be individualised, and this is in fact what occurred.

19 We understand that Dr Geppert attended a "BAC Consumer Meeting" at 8:45am on 18 December 2013, where the attendees discussed the fact that "[i]t is not safe to commence transitions at the end of January 2014" and that "[a] closure date had to be set but was not set on clinical need". Please provide further information about the content of the discussions in relation to these two issues (including why these issues were raised) and how these issues were managed in the transition process.

19.1 I attended a BAC Consumer Meeting on 18 December 2013. [redacted] [redacted].

19.2 The comment that "it is not safe to commence transitions at the end of January 2014" meant that it would not be safe to delay the commencement of transitions until the end of January 2014. That proposition is correct. It was understood that the transition processes would take some time and to have delayed commencing the process until January 2014 would almost certainly not have enabled the safe transition of patients over the December 2013/January 2014 vacation period as was being targeted.

19.3 The comment that "a closure date had to be set but was not set on clinical need" is incorrect. In that regard:

(a) The statement appears in a draft version of minutes of that meeting. That was not said at the meeting and it is not in alignment with expectations and discussions. The draft was prepared by Laura Johnson in her role as secretariat to the committee, and sent to me by email at 10.43am on 18 December 2013. Attached and marked **LG-20** is a copy of the email and attached draft.

(b) I reviewed the draft minutes and revised the content to accurately reflect the meeting discussion: 'a closure date was set for 2/2/14 however clinical needs of inpatients will be the primary drivers associated with transition plans of individuals and it may be that there are no inpatients at a time prior to 2/2/14'. I sent the revised draft to Ms Johnson and the other meeting attendees at 1.14pm on 18 December 2013. Attached and marked **LG-21** is a copy of my email and the attached revised draft.

(c) In that email I asked the meeting attendees to 'let me know if there are any

amendments required'. I have no record of receiving any requested revisions from any of the attendees. The revised draft is an accurate reflection of the discussion at the meeting.

20 We understand that West Moreton Hospital and Health Service were planning to provide an interim day program in February 2014.

(a) What involvement did Dr Geppert have in this planning process?

20.1 WMHHS arranged for Aftercare to provide a BAC Holiday Day Program for the period 16 December 2013 to 24 January 2014. Attached and marked **LG-22** is a copy of the Implementation Plan for that program with attached example weekly planner.

20.2 I was a member of the YPETRI where the model of service for the adolescent residential was developed and approved. Through this committee I was also involved in the development of the service contract for the residential program which included the provision of the sessions comprising the day program.

(b) Was this interim day program in fact provided in February 2014? If so, what were the key elements of this interim day program?

20.3 It was intended to provide an interim day program in February 2014 as part of the program at the Adolescent Residential. Attached and marked **LG-23** is a copy of the WMHHS Adolescent Residential and Day Program February 2014 reflecting the intention to provide that program.

20.4 The program was not delivered at that time because the opening of the Adolescent Residential was slightly delayed. The program commenced upon the opening of the residential in March 2014. The key elements of the program are contained in the Model of Service outline which is attached and marked **LG-24**.

21 Were any new or replacement adolescent mental health services established in Queensland immediately following/in the course of the closure of BAC? If so, did any BAC patients benefit from these new or replacement services and how?

21.1 New and replacement adolescent mental health services established in Queensland immediately following/in the course of the closure of BAC are detailed in a brief by CHQHHS and WMHHS dated January 2014 to the Minister for Health. Annexed and marked **LG-25** is a copy of that brief.

21.2

21.3

21.4 I am not personally aware of any other BAC patient accessing new or expanded adolescent mental health services, however given it is not my direct responsibility to be involved in clinical referrals, this may have occurred at some point since BAC closure without my knowledge.

22 What involvement (if any) did Dr Geppert have in the decision to stand down Dr Sadler?

(a) If Dr Geppert was not involved in this decision, when did Dr Geppert first become aware of this decision?

22.1

22.2

22.3

22.4

22.5

(b) What is Dr Geppert's understanding of the reasons for standing down Dr Sadler?

22.6

(c) Who was responsible for communications with families of BAC patients in relation to this matter, and what were the key messages communicated to families of BAC patients in relation to this matter?

22.7 Dr Terry Stedman, Clinical Director of The Park was Dr Sadler's direct line manager. He was on scheduled leave at the time of these events and Dr Darren Neillie was acting in his

position.

22.8 As requested by Sharon Kelly, Dr Neillie and I jointly telephoned the parent/carer contact for each BAC patient to advise them of the situation, although not all calls were answered during our first attempt. The key messages communicated to the parent/carer contact were that:

(a)

(b)

(c) WMHHS considered it was more appropriate to have Dr Sadler not involved during the course of the investigation.

(d) This would not affect the care of their adolescent. Clinical and other care would continue to be provided as usual and an acting Clinical Director would be appointed.

23 Were there any arrangements in place to monitor the adequacy of the transition processes for patients of BAC (and their families) and staff of the BAC?

(a) If so, what were these monitoring arrangements?

23.1 Dr Anne Brennan continued working with WMHHS as a consultant psychiatrist until March 2014. I am aware she followed up with the receiving services or the parent/carer contact for patients on an individual basis on at least one occasion after BAC closed to ascertain how the former patients were progressing. Attached and marked **LG-26** is a copy of Dr Brennan's notes of her follow up on 29 January 2014.

23.2 Families were aware that they were able to directly telephone or email Sharon Kelly or Lesley Dwyer to advise them of any concerns. I am aware this occurred in the case of at least one family.

23.3 Where there were funding packages in place, I received some ad hoc telephone calls from receiving services which may, from time to time, have included a discussion regarding the