EXHIBIT 40

STATEMENT OF DR MICHAEL I CLEARY

I, **DR MICHAEL I CLEARY**, Acting Deputy Director-General, Clinical Excellence Division, Department of Health, 147-163 Charlotte Street, Brisbane in the State of Queensland, state as follows:

1. Attachment "**MIC-1**" is a copy of a Requirement to Give Information in a Written Statement dated 11 November 2015 (Notice) directed to me from the Barrett Adolescent Centre Commission of Inquiry sent under cover of a letter from the Commission dated 11 November 2015 and received by the Department of Health on 16 November 2015. This Statement is provided in response to the Notice.

Background and experience

1. Outline your current professional role/s, qualifications and memberships. Please provide a copy of your current/most recent curriculum vitae.

2. In response to Question 1, my current professional role is Acting Deputy Director-General, Clinical Excellence Division. I have held this professional appointment since 6 July 2015. This role is due to conclude in this role on 31 December 2015. I am taking up the position of Executive Director of Medical Services, Princess Alexandra Hospital on 11 January 2015.

3. My qualifications and memberships are:

   - Fellow of Royal Australasian College of Medical Administrators – 2009;
   - Instructor, Care of the Critically Ill Surgical Patient – 2001 (previous);
   - Instructor, Pre Hospital Trauma Life Support Course – 1998 (previous);
   - Certificate in Disaster Medicine, Emergency Management Institute – 1994;
   - Master of Health Administration, University of New South Wales – 1993;
   - Associate Fellow of the Australian College of Health Services Executives – 1993;
   - Instructor, Early Management of Severe Trauma Course – 1990 (previous);
   - Fellow of the Australasian College for Emergency Medicine – 1989;
   - Board Member of the Australian Council on Healthcare Standards;
   - President of Royal Australasian College of Medical Administrators .

4. Attached to this Statement at Attachment "**MIC-2**" is a copy of my current Curriculum Vitae.

2. The Commission understands that you hold (or have held) the positions of Director-General Queensland Health (including in the capacity of A/Director General Queensland Health) and Deputy Director General Health Service and Clinical Innovation. With respect to each of these positions:

(a) state the period during which you held the position;

(b) outline your key responsibilities, including working and reporting relationships and the branches (or areas) which fell within your responsibility;

(c) detail your role and responsibilities with respect to the operation and/or management of the Barrett Adolescent Centre (BAC); and

(d). provide a copy of your position description.

5. In response to question 2, I say that I have not held the position of Director-General, Queensland Health.

6. I held the position of Acting Director-General, Queensland Health for the following periods:

- 4 February 2013 to 10 February 2013;
- 22 April 2013 to 28 April 2013;
- 18 August 2013 – 23 September 2013;
- 5 October 2013 to 12 October 2013;
- 26 October 2013 to 3 November 2013;
- 25 December 2013 to 27 December 2013;
- 20 January 2014 to 22 January 2014;
- 6 February 2014 to 22 February 2014;
- 12 December 2014 to 1 January 2015; and
- 14 February 2015 to 5 July 2015.

7. A role description is attached marked ***MIC-3***.

8. I held the position of Deputy Director-General, Health Services and Clinical Innovation Division (HSCIDD) from July 2012 to July 2015. A position description for the role is attached marked **MIC-4**. I was also appointed to the position of Chief Operations Officer for the Department of Health on 17 September 2014 and undertook this role to 14 February 2015 . An appointment letter to this position role is attached and marked **MIC-5**.

9. My key responsibilities in the role of Deputy Director-General, HSCIDD were to oversee statewide clinical support and coordination functions to assist the Hospital and Health Services and to provided leadership and direction to both the Department and the broader Queensland health system including policy coordination, public and private regulation and the identification of health system priorities.

10. The positions which reported to me in this role were the Chief Health Officer who headed up the Chief Health Officer Branch, Executive Directors of two Branches and the professional Chiefs that headed the four professional offices. The Executive Director were the Executive Director of the Mental Health, Alcohol and Other Drugs Branch and the Executive Director of the Health Systems Innovation Branch. The professional Chiefs were the Principal Medical Officer who headed up the Office of the Principal Medical Office, The Chief Nurse and Midwifery Officer who headed up the Office of the Chief Nursing and Midwifery Officer, the chief dental Officer who headed up the Office of the Chief Dental Officer and the Chief Allied Health Officer who headed up the Allied Health Professions' Office of Queensland.

11. My key responsibilities in the role of Chief Operating Officer, Department of Health was to assist the Director-General manage the workflow in the Office of the Director-General. This position did not have any direct report and operated with the delegated authority of the Director-General.

12. I reported to the Director-General, Queensland Health in these roles.

13. I had no direct responsibility with respect to the operation or management of the Barrett Adolescent Centre (BAC). The operational management of the service from July 2012 sat with the West Morton Hospital and Health Service (WMHHS). As will be seen, specific issues relating to BAC required Director-General or Ministerial decision/approval, it might be raised directly with the Director-General or might be discussed at a meeting of the Budget Review Committee, of which I was a member.

14. The Clinical Excellence Division has been in place since 3 August 2015 (following the recent restructure of Queensland Health). Attached to this Statement at Annexure "**MIC-6**" is a copy of my role description for Deputy Director-General, Clinical Excellence Division.

3. Identify and provide details of all other positions and appointments (permanent, temporary or acting) held by you in Queensland Health for the financial years 2003 -2014, which are not already detailed in response to question two above.

15. In response to question 3, I say that prior to the above positions, I held the position of Deputy Director-General, Policy, Strategy and Resourcing Division (PSRD) within the Department of Health from May 2010 to July 2012. During this period I had no oversight of the Mental Health Branch (MHB). Attached to this Statement at Annexure "**MIC-7**" is a copy of my role description for Deputy Director-General, Policy, Strategy and Resourcing.

16. Prior to this time, I was employed as:

- the Executive Director and Director of Medical Services at the Logan and Beaudesert Hospitals from December 2009 to May 2010;
- the Executive Director of Medical Services of the Southside Health Service District from April 2006 to December 2009;
- the Executive Director of Medical Services of The Prince Charles Hospital and Health Service District from April 2000 to April 2006;
- the Acting District Manager of the Prince Charles Hospital and Health Service District from September 2003 to April 2004 and August 2005 to April 2006;
- the Acting District Manager of the Bundaberg Health Service District from May 2005;
- the Acting Executive Director of Medical Services of the Toowoomba Health Service District from March 1999 to December 1999;
- the Acting Executive Director of Medical Services of the Princess Alexandra Hospital from July 1998 to February 1999;
- the Director of Medical Administration of the Princess Alexandra Hospital from July 1997 to March 2000;
- the Medical Advisor, Division of Policy and Planning Manager for the Elective Surgery Team, Queensland Health from February 1996 to July 1997;

- the Medical Superintendent of the Queen Elizabeth II Hospital from September 1996 to July 1997;
- the Acting Director Division of Emergency Medicine and Ambulatory Care of the Royal Brisbane Hospital from May 1994 to July 1995;
- the Staff Specialist Department of Emergency Medicine and Ambulatory Care, Royal Brisbane Hospital from 1989 to 1996;
- the Acting Director of Emergency Medicine of the Queen Elizabeth II Jubilee Hospital from August 1989; and
- the Emergency Physician (Visiting Specialist) of the Priority Emergency Centre, Mater Private Hospital from 1989 to 1993.

Replacement unit for the BAC

4. Outline the nature and extent of your involvement in the planning of the 15-Bed Adolescent Extended Mental Health Treatment Unit at Redlands Hospital (the Redlands unit). In particular:

(a) explain the nature and extent of your involvement, and the relevant date(s);

(b) provide details of the capital allocation to fund the Redlands unit;

(c) outline the nature and extent of your involvement (if any) in the 2004 report, "Options Study for Barrett Adolescent Centre at The Park Centre" and state the date when you received this report (and from whom), and for what purpose, and what steps (if any) you took as an outcome of the study.

17. In response to question 4(a), I was not involved in the planning of the Redlands unit. I believe that this occurred whilst I was employed in various roles within The Prince Charles Hospital Health Service District and the Southside Health Service District as they were then known.

18. I was a member of the Budget Review Committee (BRC). The first meeting of this Committee was on or about 28 May 2012. Further meetings were held regularly through 2012, 2013 and 2014. Attached at Annexure **MIC-8** is a copy of the Terms of Reference for the Budget Review Committee (BRC).

19. I recall from the BRC meetings that there had been an initial budget allocation for the Redlands unit and then on or about June 2012, a significant cost overrun was reported.

20. In response to question 4(b), as I was not directly involved I can only answer this question from what I learned on the BRC , which was that approximately $16 million (to the best of my recollection) was initially allocated to the project. In the course of preparing this statement, I now note that on 7 October 2011 an overview of Queensland Health capital projects was back copied to me in my role as Deputy Director-General, PSRD which indicated in an attachment that an allocation of $16.1 million had been made to the project. This came about because the then Premier had asked for information from the then Director-General on mental health beds.

21. In response to question 4(c), I did not have any involvement in the 2004 report, *"Options Study for Barrett Adolescent Centre at The Park Centre"* and do not recall ever receiving this report.

5. With respect to the plan to build the Redlands unit, outline:

(a) the genesis of the plan (and when it arose and the names and positions of those persons involved); and

(b) how far the planning of the Redlands unit progressed, prior to its cancellation.

22. In response to question 5(a), I was advised by Dr Kingswell in or around July 2012 that the plan for the Redlands unit was one of a number of projects funded under Stage 1 of the *Queensland Plan for Mental Health 2007-2017* Capital Works Program. I am unable to identify the names and positions of those involved in the genesis of the plan as I was not particularly involved.

23. In response to 5(b) whilst progress on the Redlands unit plan was discussed at the BRC meetings, I was not aware of the specific details regarding progression of the planning as I did not oversee the capital program. From the information provided to the BRC, I believe that by June 2012 the Redlands program had incurred multiple delays. The then Health Planning and Infrastructure Division (HPID) would normally manage this activity.

6. Outline the nature and extent of your involvement in the decision to not proceed with the development of the Redlands unit. In particular:
(a) when was the decision made and by whom, and in what circumstances;
(b) identify who else had involvement and/or input into the decision;
(c) state the reason(s) why the Redlands unit did not proceed;
(d) explain the relevance (if any) of the "Fiscal Repair Strategy" on the decision;
(e) explain your knowledge of the redirection of the capital allocation (including by whom and to where and when).

24. In response to question 6(a) I say that as I was not directly involved in the decision to not proceed with the Redlands unit, this is better answered by others. I can refer to a briefing note that I have subsequently become aware of for approval signed by the then Director-General for Health, Dr Tony O'Connell dated 16 May 2012 and a briefing to Minister for Health, signed by Dr Jeannette Young as Acting Director-General on 17 August 2012

25. In response to 6(b) I was present during discussions about the project not proceeding, in my capacity as a member of the BRC. At the time of one of the BRC meetings in or about July 2012, I recall speaking to Dr Kingswell (Executive Director, Mental Health Alcohol and Other Drugs Branch (MHAODB)) to obtain advice, as with the then changes to the Queensland Health organisational structure the MHAODB reported through my position as the Deputy Director-General, HSCID.

26. In response to question 6(b), apart from referring to the information on the said briefing note, I cannot say who else had involvement and/or input into the decision.

27. In relation to 6(c) Dr Kingswell recommended consideration of alternative models moving from institutional to community based care. Dr Kingswell also indicated that continuation of the Redlands project was not appropriate for a range of reasons including:

- the proposed unit continued a model of care that was now not considered contemporary. Contemporary models were moving from institutional care to community based care. Dr Kingswell indicated that there was work being undertaken nationally that indicated that institutional models of care were not considered contemporary under the draft "National Mental Health Service Planning Framework".

- the koala population corridor requirement;

- a water course on the site;
- a significant budget overrun of approximately $1.4 million; and

28. In response to question 6(c) I say that to my knowledge the Redlands unit did not proceed because:

    - There was a significant environmental issue which made completing the project difficult;
    - A water course was identified as a physical problem in completing the project;
    - The MHAODB provided advice that there had been a change in the model of caring for adolescent psychiatric patients which was a move away from institutional care to care in the community where the care and treatment could be provided closer to families and other social and educational supports;
    - A need to make budget savings across the whole of Queensland Health, in circumstances where the viability of the then capital project was of grave concern.

29. In response to question 6(d), with respect to the "Fiscal Repair Strategy", following the change of State Government in March 2012, the Government identified that there was a substantial budget deficit which was projected to increase significantly in the near term if corrective actions were not taken.

30. Around this time, the State Government commissioned the Commission of Audit, which identified spending patterns of different Government agencies, including Queensland Health, and raised concerns about budget management. This identified that the debt across the Queensland Government was projected at that time to increase to approximately $100 billion by 2017-2018. The attached *Queensland Commission of Audit Interim Report – June 2012* details the fiscal repair strategy. The Interim Report is attached at **MIC-9**.

31. Around this time population growth in Queensland was approximately 1.9 per cent. The growth in activity in hospitals was approximately 4 per cent per annum. The growth in health expenditure was up to approximately 12 per cent per annum. There was an overall Government revenue increase of approximately 6 per cent per annum. The Audit identified that Queensland Health was a significant contributor to the Government debt and that expenditure appeared to be in excess

of that required to meet general health needs relating to population growth and service demands.

32. In the first three months of the new State Government's appointment, Queensland Health was required to put in place savings strategies of approximately $120 million. Additional savings strategies and targets were identified for the following financial year. The whole of Government budget management strategy required Queensland Health to look at expenditure that was discretionary, could be deferred, or was not effectively contributing to improved health outcomes. The Deputy Director-General, Finance, Procurement and Legal Services for the Department of Health oversaw, monitored and reported on financial performance. Performance was reported at the BRC.

33. In response to question 6(e), my recollection of discussions at the BRC was that that capital and operational savings were directed to fiscal repair, Government election commitments and priority projects. This would, in the case of capital savings, have been managed through the then Health Infrastructure Branch (HIB).

7. Upon the decision being made not to proceed with the Redlands unit, explain whether:
(a) consideration was ever given to the following alternatives (and, if so, when and by whom and in what circumstances, and outline the reason(s) why/why not)):
(i) an alternative site for a Tier 3 service; and/or
(ii) refurbishment of the BAC; or
(b) a decision had already been made (and, if so, by whom and when) that a Tier 3 would not be developed and (if yes, the basis of that decision).

34. In response to question 7(a)(i), I say that based on advice from Dr Kingswell that the BAC was to continue operating in its then form, I believe that there was no active, immediate consideration of an alternative "Tier 3" services at the time the decision was made to not proceed with the Redlands unit.

35. To my knowledge a "Tier 3" service, was not a concept that was in existence at that time. The concept was developed as part of the proposed new service model that I first became aware of in early 2013. "Tier 3" services were one component of the then proposed new multi-level service model.

36. In response to question 7(a)(ii), on 15 October 2012, I recall seeking information from the HIB regarding whether there was an option to undertake maintenance and refurbishment for the BAC. It indicated it was possible to undertake

maintenance and that this could have been managed through the WMHHS. It indicated that a specific cost breakdown was not available.

37. I recall advice from HIB that the facility was considered unsuitable for complete refurbishment. I understood that at that time the costs of complete refurbishment were not know.

38. I response to question 7(b) I say that to my knowledge no decision had been made at the time of the decision not to proceed with the Redlands unit that a Tier 3 service would not be developed. To my knowledge the concept of "Tier 3" services was not in existence at that time.

8. At the time when the decision was made not to proceed with the Redlands unit, who would have had authority to establish an alternative Tier 3 service (had this option been progressed and a location identified)?

39. In response to question 8, I say that at the time that the decision was made not to proceed with the Redlands unit, I believe that there was no discussion regarding an alternative "Tier 3" service or equivalent. At that time, I considered that the BAC would continue to operate.

40. However, if this option had been progressed and an alternative location identified (which I reiterate did not occur), this would have been a policy consideration for Government based on advice from relevant HHS's and the Department of Health. As such the Government or the Minister for Health would have had the relevant authority. Approval would have been required for capital expenditure in line with the delegation schedule which operates within the Queensland Government.

9. Explain the relevance (if any) of the "Queensland Plan for Mental Health 2007-2017" with respect to:
(a) the genesis and development of the plan to construct the Redlands unit, and the cancellation of that plan; and
(b) consideration (or lack of consideration) of a replacement Tier 3 service at an alternative location.

41. In response to question 9(a) I say that I cannot provide any specific comment regarding the relevance of the *Queensland Plan for Mental Health 2007-2017*, Attachment **MIC-10,** to the genesis and development of the plan to construct the Redlands unit (other than it is my understanding from Dr Kingswell that the proposed Redland unit was part of the plan), or the extent of consideration given to a replacement service at an alternative location. This is because I did not oversee

mental health at those times, and was not involved in the genesis of the plan to construct the Redlands unit.

42. In response to question 9(b) I cannot explain the relevance of the plan to consideration of a replacement service at an alternative location because I was not aware of consideration occurring with respect to an "alternative Tier 3 facility" at the time a decision was made not to proceed with the Redlands unit. To my knowledge the concept of "Tier 3" services did not exist at that time.

Barrett Adolescent Centre (BAC)

10. The Commission understands that the BAC was referred to as being a 'Tier 3' service. Under what policy document or otherwise, was BAC classified as being a Tier 3 service (and provide a copy)?

43. In response to question 10, it is my understanding that Children's Health Queensland HHS (CHQHHS) led the development of the new service model. The model identified a tiered structure. My understanding is limited. Dr Kingswell would be better placed to advise in relation to this matter.

44. Within the tiered structure, there was reference made to a Tier 3 service, which was a supported inpatient model of care. Based on advice from Dr Kingswell I understand that this most closely aligns with one element of the services that were provided through the BAC.

11. With respect to the BAC:
(a) during financial years 2003 to 2014, how was the BAC funded (include detail of the nature of that funding, and any changes in financial responsibility throughout this period (and explain when those changes occurred and what they involved));
(b) how did the amount of funding required for the BAC compare as against that required for community care models of care;
(c) what were the financial implications for a state-wide facility being located within a Hospital and Health Service district and, in particular, within:
(i) the West Moreton Hospital and Health Service); and/or
(ii) the Metro South Hospital and Health Service (i.e. the Redlands unit).

45. In response to question 11, I say that up until July 2012, budget allocations were managed by Queensland Health and provided to District Health Services which were managed by a District Manager. After July 2012, Service Agreements were established by the Department of Health with the newly formed HHS's which were

statutory bodies. These Agreements included a budget allocation. Funding was negotiated with the Department of Health by each HHS in its new role as System Manager.

46. The new arrangements provided greater discretion for HHS Boards to allocate and reprioritise funding so they could best meet the needs of their communities.

47. Under this model, funding for the BAC would have been allocated to West Moreton HHS under its Service Agreement with the Department of Health. I believe that this budget allocation would have been on the basis that funding that was previously provided to Health Service Districts would be provided to newly established Hospital and Health Service.

48. As at July 2012, I believe the operational budget for the BAC was approximately $4.0 million annually.

49. In response to question 11(b), I recall that the proposed community care model if fully implemented was estimated to cost up to $20 million over time. It should be noted that this proposed model would provide a greatly expanded range of services which would be provided at a number of locations across the state. These services would be "closer to home" than those provided through the BAC.

50. I understand that the funding currently being provided to CHQHHS is approximately twice the budget initially provided to support the BAC, being approximately $8 million annually. This included funding for a "Tier 3 service" at the Lady Cilento Children's Hospital (LCCH), an additional day hospital program in north Brisbane, new community teams at 7 locations across the state and new residential rehabilitation programs in the south Brisbane region and in Cairns. In addition to this there has been an expansion of the residential rehabilitation program of up to 8 beds and 2 family units in Townsville. The Department of Health has also established 2 additional community teams in Cairns and Rockhampton following the murders of 8 children in Cairns in December 2014. I understand that the total expenditure in this area is now in the order of $12 million per annum, almost three times the expenditure provided through the BAC for this client group.

51. In response to question 11(c), I say that within the current Department of Health organisational arrangements, health services are managed through a Service Agreement and funding that is negotiated annually.

52. Specialised statewide services receive specific consideration within a HHS's Service Agreement so as to ensure that they are able to provide the required levels of clinical activity.

53. Therefore, with respect to WMHHS and Metro South Hospital and Health Service (MSHHS) providing a statewide service, funding would be included in their respective Service Agreements. There are a significant number of clinical services provided by HHS's under these types of arrangements.

12. The Commission understands that the BAC provided a statewide mental health service. Provide details as to:
(a) statewide service plans relevant to the BAC (and provide copies);
(b) State and National policies, plans and protocols, relevant to the management and operation of the BAC (and provide copies);
(c) the relationship between the BAC, the Hospital and Health Services and the Department of Health, including, but not limited to:
(i) roles in relation to accountability, oversight and responsibility for the BAC;
(ii) how statewide mental health services were developed and overseen by the Department of Health;
(iii) the role of the Mental Health, Alcohol and Other Drugs Branch with respect to the BAC.
(iv) how statewide mental health services were planned for and overseen by Queensland Health (and provide copies of any documented framework and/or planning documents which were in place between the financial years 2003 to 2014).

54. In response to question 12(a) I say that I am not aware of statewide service plans relevant to the BAC. Hospital and health Services (HHS) have a major role in the provision of services as they are required to ensure that appropriate levels of service provision are available to support their communities. As such HHS's would be the level within the agency where operational planning is undertaken.

55. The mental health planning framework in Queensland changed in 2013 with the establishment of the Queensland Mental Health Commission (QMHC). The Commission was required to produce a strategic plan. This has subsequently been published and is titled "Improving mental health and wellbeing Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019". A copy is attached at Annexure **MIC-10**

56. Following the release of the QMHC strategic plan and pursuant to Shared Commitment 7, the MHAODB have commenced the development of a *Mental*

Health, Drug and Alcohol Services Plan. Subsequent to consideration by Government it is anticipated this services plan will be released in early 2016.

57. In response to question 12(b) I am aware that Queensland Health is a signatory to the national mental health suite of planning documents which have been updated regularly since the first Mental Health Plan was produced. A copy of the Fourth National Mental Health Plan is attached at Annexure **MIC-11**.

58. I understand that the BAC provided services consistent with the *Queensland Plan for Mental Health 2007-2017* and aligned with the then national mental health plan.

59. In answer to question 12(c)(i) I say that the oversight and responsibility for BAC belonged to the WMHHS. WMHHS was accountable for the services it provided pursuant to its Service Agreement with the Department of Health. The Chair of the HHS Board reports to the Minister for Health. The Director-General had a significant role as signatory to the Service Agreement with the HHS. This Service Agreement is co-signed and agreed to by the HHS Board Chair.

60. In answer to question 12(c) (ii) I say that with the establishment of HHS's as statutory bodies, the operational planning of mental health services became the responsibility of the HHS's. The Department of Health, in responding to this change in accountability, enhanced its role with respect to monitoring health service performance. This function was coordinated by the Deputy Director-General, Health Commissioning Queensland who had mechanisms in place to monitor HHS performance. This includes drawing on performance information from other parts of the Department of Health including the MHAODB. The MHAODB monitors activities such as progression of Government policy or election commitments and patient safety indicators such as seclusion rates. These data are discussed on a monthly basis with HHS's so that any variation can be addressed.

61. In answer to question 12(c) (iii) I say that the role of the MHAODB with respect to the BAC was very limited as the service was managed by the WMHHS in accordance with the Service Agreement with the Department of Health. The MHAODB would monitor aspects of performance as per the key performance indicators set out in the Service Agreement with the HHS. The MHAODB also provided expert clinical and policy advice to the Department of Health and HHS's.

62. In answer to question 12(c) (iv) I say the Executive Director MHAODS is best placed to detail the planning framework as this sat within the MHAODB area of responsibility. My knowledge is limited. The key planning documents that I am aware of are referred to above, as is the current service planning activity that is being undertaken by the MHAODB.

13. The Commission understands that a number of statewide clinical networks sit within Queensland Health, one of which is the Mental Health Clinical Network. Provide details as to:

(a) the role and function of the Mental Health Clinical Network and, in particular, with respect to the BAC (prior to its closure);

(b) the role of the Mental Health Clinical Network (and any other Clinical Networks) with respect to approving the model of care at BAC;

(c) any concerns raised between financial years 2003 to 2014 with respect to the model of care at the BAC (and provide details as to by whom, when and what steps were taken (if any)); and

(d) whether the Mental Health Clinical Network was responsible for approving (or otherwise having oversight over) the model of care in place at the BAC prior to its closure (and if so, provide details as to the nature and extent of the approval and oversight).

63. In response to question 13(a), I say that the Mental Health Clinical Network (MHCN) was established in 2012.

64. The MHAODB established a MHCN following the establishment of the HHS's to enhance communication across the mental health clinical disciplines. This was because with the move to a de-centralised responsibility model for service provision there was a need to establish a formal structure to ensure that clinical staff remained "connected" across the state.

65. This clinical network model is similar to other Clinical Networks that operate across Queensland Health. These networks operate to enhance communication and engagement with and between clinicians.

66. Matters that could be considered by the MHCN included policy issues that the MHAODB wished to consult on. I am not aware of any matters of this nature that were consulted with the MHCN.

67. In answer to question 13(b), the Network had no formal authority to approve models of care. The Network operates in accordance with the approved Terms of Reference. These Terms of Reference are attached at Annexure **MIC-12**.

68. In answer to question 13(c) I am unable to comment on concerns raised with respect to the model of care prior to July 2012. I am not and would not be aware of any concerns that were raised through the Clinical Network unless the Executive Director MHAODB specifically raised these with me. Subsequent to me taking up the role of Deputy Director-General HSCID, of the matters raised with me by the Executive Director MHAODB, I do not recall any that related to BAC.

69. In answer to question 13(d) I do not believe the MHCN was responsible for approving or otherwise having oversight over the model of care at BAC.

14. The "Queensland Plan for Mental Health 2007-2017" refers to "Core Mental Health Services". With respect to this plan, provide details as to:
(a) the criteria for being a "core mental health service", and the implications of being (or not being) classified as a "core mental health service" (and provide copies of any applicable policy document(s)).;
(b) whether the BAC was a "core mental health service" and the reason(s) why/why not; and
(c) whether the BAC was considered to be "hospital treatment" based on the type of care provided (inpatient subacute bed-based intensive treatment and rehabilitation services), and the reason(s) why/why not (and provide copies of any applicable policy document(s)).

70. In response to question 14(a), and from my reading of the relevant documents I do not believe that the *Queensland Plan for Mental Health 2007-2017* refers to Core Mental Health Services.

71. The Plan does refer to "*core public mental health service functions*", including entry criteria, case management and inter-sectoral collaboration at page 19 and overseeing processes for linking "*core service needs*" at page 26. I am unaware of the criteria for being classified as a core mental health service or the implication for being so classified.

72. In response to question 14(b) I say that I am unable to say whether BAC was a core mental health service for the purposes in the Plan as the criteria to be so classified, if such a thing existed, are not set out in the Plan.

73. In response to question 14(c) I say that the Plan indicates that the Queensland Mental Health System includes primary health care services, private sector mental health services, community mental health services, acute inpatient and extended inpatient services, specialised statewide mental health services and community residential services (pages 6-7). I consider that the BAC would principally align with an extended inpatient service.

Closure of the BAC

15. Who had authority to approve the closure of the BAC and by what means (and what was the basis of that authority)?

74. In response to question 15, Government is recognised as the authority responsible for key policy decisions. As such the authority to approve the closure of BAC rested with the Government and in particular the Minister for Health. I also note that when the Honourable Lawrence Springborg became Minister for Health in 2012, he specifically requested that any decisions about major changes to service provision be referred to him through the Director-General so that they could be given active consideration.

16. Who made the decision to close the BAC (and on what date, and by what means, and in what circumstances)?

75. In response to question 16, I say that the Minister for Health made the decision to close BAC on 6 August 2013. The means was a public announcement.

76. I cannot comment on the decision making process however in January 2015 I became aware of a briefing prepared for the Minister in July 2013 by the WMHHS which references a proposed meeting where this matter was to be discussed. This briefing is attached at **MIC-13**

17. Explain the extent of your involvement and/or input into the decision to close the BAC. In the event that you had direct involvement and/or input into the decision to close the BAC, provide details as to:

- ***(a) the extent and/or nature of your involvement and/or input into the decision;***
- ***(b) the name and position of those other persons involved in the decision (and the nature and extent of their involvement);***
- ***(c). the reason(s) for the decision to close the BAC;***
- ***(d) any consultation with experts and/or stakeholders (and when), and the nature of the consultation;***
- ***(e). what advice/views were given by those experts and stakeholders prior to the decision, and how influential each of the perspectives was to the decision making and/or your input into the decision to close the BAC;***
- ***(f) all alternative options and/or service models considered in making and/or having input into the decision to close the BAC, and the reason(s) as to which were or were not accepted and/or implemented (and the reason(s) why);***
- ***(g) your understanding (and the source of that understanding) as to the date when alternative options and/or service models would be available to former patients of the BAC) (and what those alternative options were);***
- ***(h) whether an alternative Tier 3 service ever formed part of the decision-making process with respect to the closure of the BAC (and if so, when), and the reason why an alternative Tier 3 service was not established;***
- ***(i) all meetings, contact, telephone discussions, written communication and correspondence (including electronic) you had regarding the decision to close the BAC (and detail with whom and when, and for what purpose); and***
- ***(j) your knowledge of the redirection of the BAC's funding (including by whom and to where and when).***

77. I refer to my answer to question 18.

18. In the event you did not have direct involvement and/or input into the decision to close the BAC:

- ***(a) on what date, how and from whom, did you become aware of the decision to close the BAC;***
- ***(b) detail your understanding as to the reason(s) for the decision to close the BAC (and the source of that understanding and how and when it was obtained);***
- ***(c) outline your views as to the appropriateness of the decision to close the BAC;***
- ***(d) how, when and to whom, you communicated the decision as to the closure of the BAC, and for what purpose;***
- ***(e) provide details of all meetings, contact, telephone discussions, written communication and correspondence (including electronic) you had regarding the decision to close the BAC (and detail with whom and when, and for what purpose); and***
- ***(f) explain your knowledge (if any) of the redirection of BAC's funding (including by whom and to where and when).***

78. In relation to question 18(a), my answer to this question is outlined in my response to question 16.

79. In relation to question 18(b), I say that in January 2015 I became aware of a briefing note to the Minister for Health relating to the BAC and of a proposed meeting in July 2013 between the then Minister for Health and the Board Chair and Chief Executive of the WMHHS. This briefing note includes the following comment; "The BAC cannot continue to provide services due to the Park becoming an adult secure and forensic campus by 2014, and because the capital fabric of the BAC is no longer fit-for-purpose. Alternate statewide service options are required." I was not a party to the meeting and assume that these matters were discussed at that time.

80. Prior to the date of the proposed meeting I met with Lesley Dwyer and Dr Bill Kingswell as outlined in my response to question 18(e). During the meetings in 2013 I recall concerns being raised that:

    (i) The buildings were now not not considered suitable for the service provision;

    (ii) The site of the BAC was adjacent to a large adult forensic centre; and

    (iii) The model of care was no longer consistent with best practice.

81. The briefing note referred to in response to question 16 is relevant to this question.

82. In relation to question 18(c) and based on the advice of Dr Kingswell, Lesley Dwyer and Dr Steer (Chief Executive, CHQHHS), at the meetings referred to in question 18(e) I understand that a more contemporary and community based model was required to provide support for Queensland adolescents with mental health issues.

83. In relation to question 18(d) I did not communicate the decision to close the BAC. This was communicated as outlined in response to question 16.

84. In response to question 18(e) as it relates to communication with regard to the closure of the BAC the following summarises the nature and extent of my involvement and/or input:

    (i) On 1 November 2012 as Deputy Director-General HSCIDD I received a brief to the DG for approval to close the BAC. I returned the brief to the Executive Director MHAODB and noted any consideration of

changing the service model for this group of clients was a significant issue and would need to be led by WMHHS who were responsible for this service. Under the *Hospital and Health Boards Act (2011),* Hospital and Health Boards were established as statutory bodies and were responsible for service provision and operational planning. Attachment **MIC-14**.

(ii) After I took up my role as Deputy Director-General HSCID I became aware that consultation with stakeholders was occurring but I was not involved in that process.

(iii) On 12 November 2012 I received a copy of a memo from Lesley Dwyer, Chief Executive WMHHS regarding commencement of discussions with key experts, other health services and staff regarding the future model of adolescent mental health care in Queensland.

(iv) On 12 November 2012 I was invited by Sharon Kelly (Executive Director, Mental Health and Specialised Services, WMHHS) to a meeting on 13 November 2012, with Lesley Dwyer, Leanne Geppert (Acting Director, Strategy, Mental Health and Specialised Services, WMHHS), Sharon Kelly and Dr Kingswell regarding the Barrett Adolescent Strategy roles and responsibilities and resources required. I was not able to attend the meeting but discussed resource support with Lesley Dwyer after the meeting. I indicated that resource support would be available from the Department of Health given the potential implications of this activity.

(v) Following that meeting, I received a memorandum from Lesley Dwyer on 4 December 2012 identifying that WMHHS had engaged the services of Rowdy PR, Ms Naomi Ford, to act as West Moreton HHS's communications expert during the process. I responded to Ms Dwyer's memorandum on 13 December 2012 confirming that the Health Service and Clinical Innovation Division, through the MHAODB would provide the financial resources for this element of the project. Attachment **MIC-15**.

(vi) On 18 March 2013 I was invited to a meeting that day by Sharon Kelly with, Lesley Dwyer, Dr Leanne Geppert, Dr Kingswell, Dr Steer, Sharon Kelly and Dr Gilhotra (Chief Psychiatrist) regarding the work of the

Expert Clinical Reference Group (ECRG) and Planning Group and a proposal to include a "Tier 3" service in their recommendations. Given the previous advice that there was support for a community based model, I had not anticipated the proposal to include a component relating to extended inpatient care (Tier 3 services). Dr Geppert indicated that there was concern regarding options to transfer all clinical services to a community based model. Although I do not have a clear recollection of the details of the outcome of the meeting I believe that Dr Peter Steer gave consideration to supporting this level of care through the existing Brisbane children's hospitals and in the longer term establishing a Tier 3 service at the Lady Cilento Children's Hospital. I recall that I asked about other options that the ECRG could consider and that I was advised that they would be putting forward a recommendation with a single service model.

(vii) On 1 May 2013 I was invited to a meeting by Leanne Geppert on 6 May 2013 with Dr Steer, with Dr Steer, Lesley Dwyer, Sharon Kelly, Dr Kingswell and Dr Leanne Geppert to discuss the BAC. I recall that the meeting was to discuss the pathway for obtaining Ministerial consideration of a proposal from the WMHHS Board for a new model of care for adolescents with serious mental health issues in Queensland and, as part of this, the proposed discontinuation of the services provided through the BAC. I believe I was also provided with a copy of the ECRG recommendations at or prior to this meeting. The MHAODB supported the move to a community based model of care.

(viii) On 14 June I was invited to a meeting by Lesley Dwyer with Dr Tony O'Connell, Director-General,Queensland Health on 17 June 2015 with Lesley Dwyer, Sharon Kelly and Dr Leanne Geppert where the WMHHS briefed the Director-General on the work to date including the proposed new model of care for adolescents with serious mental health issues in Queensland and as part of this the proposed the discontinuation of the services provided through the BAC. The meeting was to seek support from the Director-General for a meeting with the Minister.

(ix) I had a role to provide advice in relation to the pathway by which decisions would be made in the newly established decentralised model

for health services in Queensland under the National Health Reform arrangements.

(x) The names and positions of the other persons involved in the process are set out above.

85. In relation to question 18(e), the redirection of BAC's funds was managed by a subgroup set up under the Chief Executive and Department of Health Oversight Committee. I understand that the initial funding provided to CHQHHS was drawn from 2 sources. These were the operational funds that previously supported BAC and new funding provided from the Department of Health made up of approximately $2.0 million allocated to support the proposed service at Redland and approximately $1.0m from within the MHAODB. These funding realignments would have been authorised by the Deputy Director-General, Health Commissioning Queensland and approved by the Director-General.

19. Outline the nature and extent of your involvement and/or input into the decision that the closure date for the BAC was to be January 2014. In the event you had direct involvement and/or input into the decision that the closure date for the BAC was to be January 2014, detail:
(a) the extent and/or nature of your involvement and/or input into the decision and the names and positions of those other persons involved in making the decision;
(b) the reason(s) as to why January 2014 was chosen for the closure of BAC;
(c) on what date the decision as to the closure date was made;
(d) any consultation with experts and/or stakeholders (and when), and the nature of the consultation;
(e) what advice/views were given by those experts and stakeholders prior to the decision, and how influential each of the perspectives was to your decision making and/or input into the decision;
(f) the existence of any flexibility with respect to the January 2014 closure date, once set, or any review mechanisms; and
(g) how, when and to whom, you communicated the decision as to the closure date (and for what purpose).

86. In response to question 19, I say that I did not have any direct involvement or input into the decision that the closure date for the BAC was January 2014.

20. In the event you did not have any direct involvement and/or input into the decision that the BAC's closure date was to be January 2014:
(a) on what date, how and from whom, did you become aware of the decision that the closure date would be January 2014;
(b) any reason(s) communicated to you as to the reason for the closure date and from whom, by what means, and on what date; and
(c) the extent to which you were aware of the existence of any flexibility

with respect to the closure date or any review mechanisms (and the source of that understanding).

87. In response to question 20(a), I became aware of the potential closure date in late 2013 when this matter was discussed at the Chief Executive and Department of Health Oversight Committee (CEDoHOC) meetings. In preparing this statement I became aware that the proposed closure date was included in the "Project Plan - Statewide Adolescent Extended Treatment and Rehabilitation Implimentation Strategy (October 2013)" that was developed by CHQHHS and tabled at the CEDDSoHOC on 17 October 2013.

88. In response to question 20(b), I say that in late 2013 I sought additional advice in relation to the proposed closure date from Dr Kingswell. Dr Kingswell advised me that the BAC normally closes a range of its services for an extended period over the December/January period and that clients of the service where possible spend time with their families during this time. Dr Kingswell also advised that appropriate support arrangements would be established for transition clients. Options as I understood them included clients remaining at the BAC or transferring to the Mater Children's Hospital where continuing treatment and support could be provided or transferring clients to other specialised inpatient services.

89. In response to question 20(c), and based on the above advice, I believed that the transition arrangements were flexible and able to respond to specific client needs.

90. Clinical advice in respect of individual client needs would have been key as the transition of clients was planned.

91. In terms of a review mechanism, the review process as I understood it was overseen by the WMHHS in collaboration with CHQHHS.

21. Did you consider the January 2014 closure date to be appropriate and outline the reason(s) as to why/why not?

92. In response to question 21, I say that I became aware of the potential closure through my discussions about timeframes with Dr Kingswell. I was seeking to understand if the timeframe would allow for the required transition activities to be completed. Dr Kingswell indicated that the timeframe was acceptable noting that

flexibility existed with the transition of clients to other inpatient services or to community models. Had I had residual concerns I would have raised these with the Chief Executive WMHHS.

22. Did you facilitate or attend any meetings regarding the closure of the BAC and, if so, with whom and on what date(s), and for what purpose?

93. In response to question 22, which I understand relates to the January 2014 closure of the BAC, I do not recall if I facilitated or attended any meetings regarding the January 2015 closure date for the BAC. I did however attend the CEDoHOC where this matter was discussed.

23. Detail any processes that you were involved in (or were otherwise aware of), with respect to communicating the closure decision to parents of BAC patients (and their families) and BAC staff, and the nature of your involvement (and when).

94. In response to question 23, I say that communication of the closure decision to parents of the transition patients and their families, and BAC staff was managed by the WMHHS. I did not have any direct involvement in this process.

95. On 7 August 2013, I received a copy of an information and media communication statement from Sharon Kelly.

96. On 3 October 2013, I received a copy of the BAC Communiqué 1 and Fast Fact Sheet (No. 8) that had been forwarded to Dr Kingswell from Dr Leanne Geppert. I understood from Dr Kingswell that a meeting was held that day with staff and patients and that Dr Kingswell had been advised that the meeting had gone well.

97. I understand that a series of Fast Fact Sheets and BAC Communiqués were issued by the West Morton HHS.

24. Explain the relevance (if any) of the "Queensland Plan for Mental Health 2007-2017" to:
(a) the initial plan to decommission the BAC and build the Redlands unit;
(b) the decision not to proceed with the Redlands unit;
(c) the decision to close the BAC;
(d) the decision to close the BAC by January 2014; and
(e) the decision to announce the closure of the BAC on 6 August 2013

98. In response to question 24, the deinstitutionalisation of services provided at The Park Centre for Mental Health was part of the reform agenda under the *Queensland Plan for Mental Health 2007-2017* This plan included a project that had as an

objective the decommissioning of the BAC and the construction of the Redlands unit.

99. The *Queensland Plan for Mental Health 2007-2017* was written at a time when Queensland Health was a corporate structure where the then District Health Services were directly managed by Queensland health. The Plan was also written after the Third National Mental Health Plan.

100. The relevance of the *Queensland Plan for Mental Health 2007-2017* is diminishing because:

(a) The Fourth National Mental Health Plan has superseded the Third National Mental Health Plan and the Fifth National Mental Health Plan is about to be released;

(b) The Queensland Mental Health Commission has been established and has taken on the role of strategic planning within mental health. The Commission has published a strategic plan which in terms of the states planning frame provides a contemporary mental health strategic plan;

(c) The Department of Health is currently working on a new Mental Health Alcohol and other Drug Services Plan that will be aligned with the Queensland Mental Health Commission's strategic plan; and

(d) There are new organisational arrangements with the creation of 17 and now 16 independent Hospital and Health Services as statutory bodies as at July 2012.

101. Whilst noting that I was not actively involved in the decisions relation to 24(a)-(e) as outlined elsewhere in this statement, I do not believe that the *Queensland Plan for Mental Health 2007-2017* would have been a major consideration in relation to the decision not to proceed with the Redlands unit, the decision to close the BAC and to do so in January 2014, or the decision to announce the closure of the BAC on 6 August 2013. Whilst the Plan contemplated de-institutionalisation and moves to community based models of care, other factors contributed to these decisions.

25. Explain the relevance (if any) of the redevelopment of The Park as an adult forensic facility and/or the opening of the EFTRU facility, to:
(a) the initial plan to decommission the BAC and build the Redlands unit;
(b) the decision to not proceed with the Redlands unit;
(c) the decision to close the BAC;
(d) the decision to close the BAC by January 2014; and
(e) the decision to announce the closure of the BAC on 6 August 2013.

102. In relation to question 25, I understand that The Park Centre for Mental Health had been identified as the location where specialised forensic services would be located.

103. In relation to question 25(a) I am not able to directly comment as I was not involved in this planning process. I understand however from Dr Kingswell that this was a consideration.

104. In relation to question 25(b) and from information I obtained at the BRC I do not believe this was an active consideration.

105. In relation to question 25(c), (d) and (e), I am unable to provide specific comment as I was not directly involved in these decisions. These may be matters that can be better addressed by the Chief Executive WMHHS.

26. The Commission understands that the decision to close the BAC was announced by the former Health Minister on 6 August 2013 during an interview with the media. Explain:
(a) the circumstances in which it was decided that the Health Minister would make the announcement on this particular date and via a media interview; and
(b) the reason(s) as to why the decision to close the BAC was announced on 6 August 2013 (as opposed to some other date), including but not limited to, the relevance (if any) of the opening of the EFTRU.

106. In response to question 26, I am not able to comment as I am not aware of the circumstances or the reasons why the decision to close the BAC was announced on 6 August 2013.

27. Explain the relevance (if any) of the "National Mental Health Service Planning Framework" on decisions made with respect to the Redlands unit and/or the BAC, and state whether you received a copy of the framework (and from whom, on what date, and for what purpose) (and provide a copy).

107. In response to question 27, I understand that a key product of the National Mental Health Service Planning Framework is a tool to inform mental health resource allocation.

108. I am not in a position to say with any reliability the extent to which it had any impact on the decisions which were made regarding Redlands or the BAC.

109. I have not been provided with a copy of the draft National Mental Health Service Planning Framework and am unable to provide a copy of the framework.

Working Groups/Committees

28. The Commission understands that in around November 2012, an Expert Clinical Reference Group (ECRG) was formed to make recommendations with respect to models of care for mental health treatment and rehabilitation for adolescents in Queensland. With respect to the ECRG:

(a). outline the nature and extent of your involvement in the formation of the ECRG, including but not limited to, the selection of its members (and the basis for their selection);

(b) outline the nature and extent of your involvement in the functions of the ECRG. In particular, provide details as to:

(i) your understanding as to the function of the ECRG and the report to be prepared by the ECRG;

(ii) the development of the Terms of Reference, the scope and functions of the ECRG and the material to be considered by the ECRG;

(iii) any input or direction given by you (or on your behalf) to the ECRG (or its members);

(iv) any consultation by you (or carried out on your behalf) with the ECRG (or its members); and

(v) any oversight and/or monitoring role which you played with respect to the ECRG.

(c) provide details as to your understanding of the purpose of the ECRG and, in particular, the relationship between the ECRG and the Barrett Adolescent Strategy Project Plan (as prepared by West Moreton Hospital and Health Service;

(d) Did you receive a copy of the ECRG report and, if so, when and how, and what action did you take.

110. In response to question 28(a), I say that on 13 November 2012, Lesley Dwyer consulted with me in relation to the governance that WMHHS proposed to put in place in relation to a review of the model of care for adolescence with severe mental illness as it related to the BAC. The discussion related to the proposed governance model, that being an ECRG reporting to a Planning Group reporting through to the West Moreton HHS Board. We also discussed the secondment of Dr Leanne Geppert to assist with the planning, communication and engagement.

111. I do not believe I was involved in the selection of the ECRG's members. At that time, I noted the Terms of Reference for the ECRG and noted that there was an external expert and the MHAODB was represented.

112. In relation to question 28(b), on 18 March 2013, the proposed Project Plan was provided to me and a discussion around the Project occurred. I note my comments above in response to Question 18 with respect to this meeting.

113. In relation to question 28(b)(i), my understanding of the key functions of the ECRG was as stated in the Terms of Reference. Attached at Annexure **MIC-16** is a copy of the Terms of Reference for the ECRG and the ECRG Recommendations.

114. In relation to question 28(b)(ii), I was not involved in the development of the Terms of Reference, the scope, and the functions of the ECRG or the material to be considered by the ECRG.

115. In relation to question 28(a)(iii), I did not have any input or give direction to the ECRG or its members. The ECRG was part of the governance model established by WMHHS.

116. In relation to question 28(a)(iv), I did not consult with ECRG members other than to attending meetings where Leanne Geppert the Chairperson of the ECRG was in attendance. These meetings are outlined in in my response to question 18. [?? Check members of ECRG from MIC-16 as against answer to Q18.]

117. In relation to question 28(b)(v), I did not have an oversight or monitoring role with respect to the ECRG as this was managed by the WMHHS.

118. In relation to question 28(c) from the Terms of Reference, I note that the purpose of the Expert Clinical Reference Group was to provide expert clinical advice to promote the development of a contemporary evidence based model of care to meet the needs of adolescent mental health consumers who experience severe and persistent psychiatric symptomatology. I cannot comment in any detail on the relationship between the ECRG and the Barrett Adolescent Centre Project Plan which is attached and marked **MIC-17** as this is a matter for the WMHHS to advise on as the owner of the plan.

119. In relation to question 28(d), on 6 May 2013, at the invitation of Leanne Guppert I attended a meeting with Dr Peter Steer, Lesley Dwyer, Sharon Kelly, Dr Kingswell and Dr Leanne Geppert. I believe that I was provided with the ECRG recommendations at this meeting.

120. I did not form a view in relation to the recommendations. The recommendations were still to be considered as part of a governance pathway as outlined by WMHHS.

121. ECRG was an element of the WMHHS governance model and as such operational management which fell to the WMHHS.

29. Outline your views in respect of each of the recommendations made by the ECRG in its report.

122. In response to question 29, I say that at the time, I had not formed a view on the recommendations given that they were still to be progressed through the WMHHS's governance processes. I noted the proposed Tier 3 service and that this was discussed at the meeting as outlined in my response to question 18.

30. In its report, the ECRG found inpatient extended treatment and rehabilitation care (tier 3) to be an essential service component. The ECRG further found that "interim service provision if BAC closes and Tier 3 is not available is associated with risk". With respect to these findings by the ECRG, outline:

a) whether the option of a tier 3 service was ever reconsidered/revisited, following receipt of this recommendation by the ECRG (and the reasons why/why not);

b) in the event the option of a tier 3 service was reconsidered/revisited, the nature of that consideration, who was involved and when;

(c) the reason(s) why a tier 3 service was not developed or implemented, given the findings of the ECRG that tier 3 was an essential service component;

d) your views in respect of the risk identified by the ECRG, and any steps or actions taken by you as a consequence of this risk/to address this risk, in circumstances where a tier 3 service was not developed.

123. In response to question 30(a) I say that the Tier 3 service was considered following the report from the ECRG.

124. In response to 30 (b) I recall that the option to address the need for a Tier 3 service was discussed with Lesley Dwyer, Dr Peter Steer and Dr Kingswell and the other members of the CEDoHOC, following advice from Dr Stathis.

125. In response to question 30(c), I say that a Tier 3 service was established by CHQHHS. The arrangements as I understood them allowed for 2 extended treatment inpatient beds to be available at the Mater Children's Hospital upon the closure of the BAC. Following the opening of the Lady Cilento Children's Hospital (LCCH) these beds would transfer to the LCCH. Four extended treatment inpatient

beds would then be available to support those adolescent clients that required Tier 3 services. I further understand that the bed requirements would be reviewed based on demands for the services.

126. I recall that Dr Stathis and Dr Kingswell advised the CEDoHOC that given the transition to a community based model from an institutionalised model for clients of the BAC, the initial two extended treatment inpatient beds and subsequent four extended treatment inpatient beds at the LCCH were expected to meet the demands for this level of services. I understand from Dr Kingswell that this service has had a small number of admissions since these beds were established. This action I believe mitigated the risk identified in the ECRG recommendations.

127. In response to question 30(d) I say that a Tier 3 service was developed by the CHQHHS.

31. The Commission understands that on 18 March 2013 you received an email from Ms Sharon Kelly, requesting an urgent meeting that afternoon to discuss the "ramifications" for Queensland Health of the service model proposed by the ECRG.
With respect to Ms Kelly's email, and the meeting on 18 March 2013:
(a) provide details as to the matters discussed at that meeting including, but not limited to, any discussion about the inclusion by the ECRG of a tier 3 model in its recommendations;
(b) provide details as to what were the "ramifications" referred to by Ms Kelly in her email; and
(c) provide details as to the outcome of the discussion and any decisions made/action taken following the meeting (and when and by whom).

128. In response to question 31(a) I say that this meeting is summarised in my response to question 18. The proposed tiered service model as outlined by the ECRG was discussed at the meeting with Sharon Kelly and others on 18 March 2013. In particular, the discussion included how the Tier 3 model could be achieved given the service arrangements that would be in place.

129. In response to question 31(b) I am unable to state what the "ramifications" were as referred to by Ms Kelly in her email other than that the view of WMHHS and CHQHS was that a Tier 3 could take time to develop.

130. In response to question 31(c), the outcome of the discussion was that the ECRG recommendations be provided to the Planning Group for their consideration.

32. The Commission understands that the ECRG was overseen by a Planning Group. With respect to the Planning Group:

(a) outline the nature and extent of your involvement with respect to the formation of the Planning Group and the selection of its members;

(b) outline the nature and extent of your involvement in the functions of the Planning Group. In particular, provide details as to:

(i) the development of any Terms of Reference, the scope and functions of the Planning Group and the material to be considered by the Planning Group;

(ii) any input or direction given by you (or on your behalf) to the Planning Group (or its members);

(iii) any consultation by you (or carried out on your behalf) with the Planning Group (or its members); and

(iv) any oversight and/or monitoring role which you played with respect to the Planning Group,

(c) state when you received a copy of the Planning Group report and outline by what means and for what purpose (and any steps taken by you as a result);

(d) outline your views in respect of each of the recommendations made by the Planning Group.

131. In response to question 32(a), I do not recall having any specific involvement with respect to the formation of the Planning Group and the selection of its members. Attached are their Terms of reference **MIC-18**

132. In response to question 32(b), I was not involved in the development of the Planning Group's Terms of Reference and I did not provide any input, direction, consultation, oversight or monitoring. I was aware from my role as Deputy Director-General HSCID that the group had been formed to oversee service model recommendations developed under the Barrett Adolescent Strategy.

133. On 29 November 2012, I received a notification about a teleconference of the Planning Group from Lesley Dwyer. I did not attend it or any other meeting of the Planning Group.

134. In response to question 32(c) I received a copy of the Planning Group's Terms of Reference and a copy of the ECRG recommendations with the Planning Group comments. On the terms of reference were sent to me by for the purposes of updating me on the processes in place within the WMHHS with regard to the Barrett Adolescent Strategy. I took no steps as a result of receiving the Planning Group's comments as their advice was yet to be formally considered by the WMHHS.

135. In response to question 32(d), I do not believe the Planning Group made recommendations. Rather they provided comments on recommendations by the ECRG. I did not form a view in relation to the comments.

136. The Planning Group was an element of the WMHHS governance model and as such operational management fell to the WMHHS.

33. As noted above, in its report, the ECRG found a tier 3 to be "an essential service component" and recommended that a tier 3 be prioritised. In its report, the Planning Group accepted this recommendation by the ECRG "with considerations". These considerations were described as follows:

Further work is needed to detail the service model for a Tier 3. Models involving a statewide, clinical bed-based service (such as the Barrett Adolescent Centre) are not considered contemporary within the National Mental Health Service Planning Framework (in draft). However, there are alternative bed-based models involving clinical and non-clinical service components (e.g., Y-PARC in Victoria) that can be developed in Queensland to meet the requirement of this recommendation. Contestability reforms in Queensland may allow for this service component to be provider agnostic.

With respect to the above extract, outline:

(a) what further work (if any) has been undertaken in Queensland "to detail the service model for a tier 3 " (and provide details as to when and by whom and the status of that work);

(b) whether you consider a statewide, clinical bed-based service to be contemporary within the National Mental Health Service Planning Framework and the reason(s) why/why not;

(c) any steps taken to develop and/or implement alternative bed-based models involving clinical and non-clinical service components such as, but not limited to, Y-PARC (and provide details as to when and by whom and the status); and

(d) your understanding of the meaning of: "Contestability reforms in Queensland may allow for this service component to be provider agnostic".

137. In response to question 33(a), I say that CHQHHS established an arrangement with the Mater Children's Hospital to provide two extended treatment inpatient beds to meet the needs of this client group (i.e. Tier 3 level).

138. Four extended treatment inpatient beds became available with the opening of the LCCH in November 2014. That number was to be reviewed depending on the clinical needs for this service.

139. In response to question 33(b), I say this question would be best answered by the Executive Director, MHAODB.

140. In response to question 33(c), I say that a number of new contemporary mental health services, including bed-based models, have been implemented across Queensland in the last few years. This is as a result of the model developed by CHQHHS known as the Adolescent Mental Health Extended Treatment Initiative (AMHETI), which recommends five key service elements, being:

_____(a) Statewide subacute beds;

(b) Day programs;

(c) Assertive mobile youth outreach services;

(d) Step up/step down units; and

(e) Residential rehabilitation units (Youth Resi).

141. As a result I understand that the following service enhancements have been implemented:

(a) The 8 bed adolescent unit and 12 place day program at Townsville commenced operation in January 2014 and the 8 bed adolescent acute unit and 14 place day program at Toowoomba commenced operation in August 2012;

(b) YPETRI, located at Greenslopes has been operational since February 2014 and provides a life skills program and a staffed residential service (24/7) for up to 5 beds;

(c) A Cairns service provides 5 beds, which is residential support provided by the non-government sector;

(d) Two new youth residential services are currently being established in Townville (8 beds and 2 family units);

(e) Since February 2014, the Mater Children's Hospital has offered 24/7 bed-based services with education support;

(f) A four bed residential rehabilitation unit opened in Brisbane's South in February 2014;

(g) Day programs are offered in Townsville, Darling Downs, Metro North and Metro South;

(h) Assertive Mobile Youth Outreach Services were established in Townsville, Darling Downs, Metro North (North Brisbane and Redcliffe/Caboolture), Metro South (South Brisbane and Logan), Cairns and Central Queensland. The final team is currently being recruited for the Gold Coast; and

(i) Two additional Assertive Mobile Youth Outreach Services have been established to support indigenous communities following the murder of 8 children in Cairns in December 2014.

(j) An update on these initiatives is attached at Annexure **MIC-19.**

142. In response to question 33(d), my understanding of "Contestability reforms in Queensland may allow for this service component to be provider agnostic" refers to a then government policy of testing the market to see if a service can be better sourced through a private provider than through a government agency. For example in relation to the services outlined in above, the residential rehabilitation services are generally provided by non-government organisations.

143. Contestability principles are outlined in the Queensland Commission of Audit Report Final Report - February 2013 which is attached Annexure **MIC-20**. The report provides the following commentary at page 1-10.

- "Better value for money in the delivery of front-line services can be achieved through contestability, as this will encourage more efficient and more innovative service delivery, whether by the public sector or the private sector (public sector service providers should not be immune from competitive pressures)."

34. In its report, the ECRG found "interim service provision if BAC closes and Tier 3 is not available is associated with risk". With respect to this finding, the ECRG recommended (together with other matters) that "safe, high quality service provision for adolescents requiring extended treatment and rehabilitation requires a Tier 3 service alternative to be available in a timely manner if BAC is closed". The Planning Group's recommendation with respect to the ECRG' s recommendation was - "Accept".
With respect to these matters, outline:
(a) what are the "safe, high quality services" for "adolescents requiring extended treatment and rehabilitation" which are an alternative to a Tier 3 service (and provide details as to when they were implemented and what they involve); and
(b) the basis upon which the alternative was assessed as being a "safe, high quality" service (and by whom and by what means, and what it involves).

144. In response to question 34, I believe that the response to question 30 addresses this matter in detail. As noted the Chief Executive of CHQHHS established additional extended treatment inpatient beds at the Mater Children's Hospital and then at the newly commissioned LCCH . These beds allowed for Tier 3 services to be provided.

145. In response to question 34(a) and (b) this is a clinical policy interpretation and would be appropriately addressed by a specialist in this field of mental health such as the Executive Director MHAODS, the Chief Psychiatrist, or the Director of Child and Youth Mental Health Services within the CHQHHS.

35. Provide details of any other committees or groups you were a member of, or had involvement or input into the formation of, with respect to the operation and/or closure of the BAC, the option of the Redlands unit, and/or the development or implementation of AETR service options.

146. In response to question 35 I say that I was a member of the CEDoHOC that met between October 2013 and January 2014. The key purpose of this group was to provide strategic leadership and governance for the Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy.

147. My involvement with the ECRG and the Planning group is outlined elsewhere in this statement.

36. The Commission understands that the following working groups/committees were in existence at around the time when decisions were being made within Queensland Health with respect to the BAC:

(a). Barrett Adolescent Centre Strategy Planning Group;
(b) The Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Steering Committee;
(c) Chief Executive and Department of Health Oversight Committee;
(d) Service Option Implementation Working Group;
(e) Barrett Adolescent Centre Consumer Transition Working Group;
(f) Financial and Workforce Planning Working Group; and
(g). Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee.

With respect to each of these groups/committees (and any other groups/committees of which you are aware, which concerned the BAC), provide details as to:

(i) the role and function of the group (both generally and also in respect of the BAC specifically);
(ii) the circumstances and purpose for which each was established (and by whom and the period for which they operated; and
(iii) the nature and extent of your involvement and/or input (and when).

148. In response to question 36 (a), (b), (d), (e), (f) and (g) I cannot provide details about the role and function of the these groups as I was not involved in the set up or operation.

149. In relation to question 36(c), I was a member of the CEDoHOC.

150. The Committee which I had direct knowledge of, and input into was the CEDoHOC.

151. On 26 September 2013 I received a memo from the Chief Executive of CHQHHS seeking to formalise the previously ad hoc advisory role of the Chief Executive and Department of Health group regarding strategic direction and guidance to the Barrett Adolescent Strategy. A copy of the memorandum is attached at **MIC-21**.

152. I attended the first meeting of the CEDoHOC on 17 October 2013. The proposed Terms of Reference, the Statewide Adolescent Extended Treatment and Rehabilitation (AETR) Project Plan and the Communication Plan were discussed. The Terms of Reference are attached at **MIC-22**

153. The Chief Executive and Department of Health Oversight Committee endorsed the *Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Project Plan* in October 2013.

154. On 13 November 2013, I received final versions of the Terms of Reference, the Statewide Adolescent Extended Treatment and Rehabilitation Project Plan and the attached Expert Clinical Reference Group's seven recommended elements. Draft versions of the Communications Plan and AETR service continuum (Model of Care) were also provided for discussion at the second meeting of 15 November 2013.

Transition Arrangements

37. The Commission is aware that during 2013 up until early 2014, a number of BAC patients were transitioned to alternative care arrangements. With respect to the Transition Clients:

(a) who was responsible for developing the transition arrangements for the Transition Clients, and what were those transition arrangements;

(b) who had the monitoring or oversight role for the transition arrangements for the Transition Clients;

c) provide details as to how transition arrangements were developed, including but not limited to, any consultation(s) with Transition Clients and/or their families, friends or carers (and the date and detail of such consultation(s));

(d) outline the nature and extent of your role with respect to Transition Clients. In particular, detail your involvement in developing, managing and implementing transition arrangements (including, but not limited to, identifying, assessing and planning for care, support, service quality and safety risks);

(e) what feedback or advice did you receive (and from whom and when) in relation to the progression of the transitioning arrangements for the Transition Clients;

(f) did you meet with any of the BAC transition clients or their families / carers in relation to their transition from the BAC and, if so, when and for what purpose;

(g) advise whether there were any transition plans to review the transition arrangements and outline what such review involved (and when and how it occurred).

155. In response to question 37(a) I understand that the WMHHS in collaboration with receiving HHS's were responsible for developing the transition arrangements for the Transition Clients. I am not able to detail what the transition arrangements were as these were managed by the WMHHS.

156. In response to question 37(b), I say that WMHHS had monitoring and oversight for the Transition Clients. The WMHHS had direct management responsibility for the BAC.

157. In response to question 37(c) I cannot provide details of how the transition arrangements were developed as I did not have an involvement in that process. I received a copy of a Brief intended for the Minister for Health from Deborah Miller on 26 November 2013. The Brief was by way of background information for me. I understood from that Brief that each Transition Client had a transition plan and the care planning for each Transition Client was being progressed by WMHHS.

158. On 12 November 2013, I received an email from Dr Kingswell regarding two issues raised by Lesley Dwyer and that related to the establishment of residential support and day hospital programs to support Transition Clients. I recall endorsing the course of action proposed by Dr Kingswell.

159. In answer to question 37(d) I did not have a role with respect to the Transition Clients or their families/carers and had no involvement in developing, managing and implementing transition arrangements.

160. In answer to question 37(e), I do not believe I received advice or feedback or advice regarding the transition of transition clients at the CEDoHOC. The CEDoHOC received high level updates of progress with transition planning.

161. In answer to question 37(f), I did not meet with transition clients or their families/carers.

162. In answer to question 37(g), I was not aware whether there were any plans to review the transition arrangements as this was managed by the WMHHS.

38. Did you have any discussions with the medical or other staff at receiving alternative services regarding the Transition Clients' transitional arrangements, transition plans, treatment plans, clinical and educational needs or other matters? If so, explain the nature of these discussions, including the date on which they occurred, with whom and for what purpose.

163. In response to question 38 I say that I did not have any discussion with medical or other staff about receiving alternative services regarding the Transition Clients' transition arrangements.

39. Were you aware of any concerns regarding the transition of any Transition Clients from the BAC to an alternative service provider? If so:
(a) detail any such concerns;
(b) if there were concerns, state who were these concerns expressed by and to whom;
(c) on what date and by what means did you become aware of these concerns; and
(d) what steps, if any, did you cause to be undertaken as a result of any such concerns.

164. In response to question 39, I was not aware of any unresolved concerns regarding the transition of Transition Clients from the BAC to alternative service provider at the time of the transition. [redacted]. I became aware of concerns regarding 2 Transition Clients

when I received a copy of a Briefing to the Director-General dated 6 January 2013 on 14 July 2015, which is attached and marked **MIC-23**. This Briefing note indicates that the Director-General sort to address these concerns with Dr Kingswell.

40. The Commission understands that you were (or are) a member of the Chief Executive and Department of Health Oversight Committee. With respect to this Committee:
(a) state the period during which you were a member;
(b) outline your role and responsibilities, and state who else was a member;
(c) outline the function and responsibilities of the Committee with respect to the BAC including, but not limited to:
(i) the decision to close the BAC;
(ii) the date for closure of the BAC;
(iii) the BAC School;
(iv) staff of BAC and the BAC School;
(v) the arrangements made for Transition Clients; and
(vi) the development and implementation of service options.

165. In response to question 40(a), I say that I was a member of the CEDoHOC from its inception until its cessation, but was not able to attend every meeting. The first meeting of the CEDDoHOC was held on 17 October 2013 and a second on 15 November 2013. A Final meeting of the CEDoHOC was held on 23 January 2014 however I was not able to attend that meeting.

166. In response to question 40(b) I say that my role on the committee was as set out in the Terms of Reference. The other members of the committee are also set out in the terms of Reference. Attached to my statement at Annexure **MIC-22** is a copy of the CEDoHOC Terms of Reference.

167. In response to question 40(c) (i), (iii) and (iv) the committee did not have any function or responsibility with respect to the decision to close the BAC, or the date for closure of the BAC. The BAC School and the staff of the BAC were not within the scope of the functions of the Committee.

168. In response to question 40(c)(ii) and as outlined in my response to question 20 the proposed closure date was included in the "Project Plan - Statewide Adolescent Extended Treatment and Rehabilitation Implimentation Strategy (October 2013)" that was developed by CHQHHS and tabled and endorsed at the CEDDSoHOC on 17 October 2013.

169. In response to question 40(c) (v) and (vi) the arrangements made for the Transition Clients and service options, the Committee was updated on the overall

program of work and the achievement against the implimentation plan by way of a status reports.

41. Provide details of any meetings, contact, telephone discussions, written communication and correspondence (including electronic) you had regarding the treatment and care plans, including ongoing health and wellbeing of Transition Clients after the closure of the BAC. In particular:
(a) did you meet with any of the Transition Clients or their families/carers? If so, who did you meet and what was discussed;
(b) did you receive any advice or feedback into the transition arrangements for the Transition Clients after the closure of the BAC? If so, what advice or feedback did you receive; and
(c) did you receive any advice as to the treatment or care plans for the Transition Clients?

170. In response to question 41(a) I say that I did not meet with any of the Transition Clients or their families / carers after the closure of the BAC.

171. In response to question 41(b), I do not recall receiving any advice or feedback about the transition arrangements for the transition clients.

172. In response to question 41(c), I say I did not receive any advice regarding the treatment or care plans for the Transition Clients.

BAC Staff

42. Explain the nature and extent of your involvement in the decision to stand down Dr Trevor Sadler. In particular, outline:
(a) the nature of your involvement in the decision to stand down Dr Sadler;
(b) on what date you first became aware of the matters the subject of the decision to stand down Dr Sadler, and from whom and by what means, and for what purpose;
(c) the reason(s) why Dr Sadler was stood down.

173. In response to question 42(a), I say that I was not involved in the decision to stand down Dr Sadler. This was a matter for the Chief Executive, WMHHS. I understand that Dr Sadler was stood down

174.

175. Based on Dr Kingswell's advice, I made some inquiries with Lesley Dwyer with regard to how she was planning to manage the matter. I understood from Ms Dwyer that she had requested urgent advice in relation to the matter from Human Resource Services within the WMHHS.

176. Ms Dwyer prepared a Briefing to the Director-General urgently. Ms Dwyer indicated that she would ensure that the appropriate authorities were notified of the matter .

177. On 9 September 2013, I received a formal briefing from Ms Dwyer in relation to this matter. This Briefing was subsequently provided to the Minister for Health for his information.

178. As is my usual practice in matters such as this I confirmed that referrals to the Crime and Misconduct Commission and the Australian Health Practitioners Regulatory Authority had been made and this was confirmed on 10 September 2013. Struck Out by the Commissioner on 25 February 2016

179. Around this time Dr Kingswell advised that two psychiatrists, namely Dr Elisabeth Hoehn and Dr Anne Brennan, would take up clinical duties at the BAC.

180. On 11 September 2013, a draft Potential Parliamentary Question and updated brief were requested through the Office of the Director-General.

181. In response to question 42(c), I say that this is a matter for the Chief Executive WMHHS.

43. Explain the extent of your involvement in the decision to appoint Dr Anne Brennan to the BAC. In particular, outline the extent of your involvement in:
(a) the decision to appoint Dr Brennan (and the date when this decision was made and by whom and in what circumstances); and
(b) providing briefing(s) to Dr Brennan with respect to her role at BAC (and the content of that instruction).

182. In response to question 43(a), I say that I was not involved in the decision to appoint Dr Brennan to the BAC. I was informed by Dr Kingswell that Dr Steer had arranged for two psychiatrists from the Royal Children's Hospital to provide clinical services at the BAC at short notice. Dr Kingswell advised that Dr Brennan and Dr Hoehn would fill these roles.

183. I did not know Dr Brennan however Dr Kingswell advised that Dr Brennan was a Senior Psychiatrist and was well placed to take on this role.

184. In response to question 43(b), I say that I have never met nor provided any briefings to Dr Brennan. Dr Brennan attended the CEODoHOC on one occasion where I was in attendance.

44. Provide details of any concerns held by you, or raised with you, in respect of staffing of the BAC, during the period 6 August 2013 until the closure of the BAC in January 2014 (and state any action taken by you as a result).

185. In response to question 44, I say that staffing within HHSs, and specifically the BAC, was a matter for WMHHS. Apart from the gap in medical leadership where Dr Brennan and Dr Hoehn were appointed to assist, I am not specifically aware of any staffing issues.

186. I believe that there was mention made at the CEDoHOC meeting that some staff at the BAC were looking for new employment opportunities. The loss of staff in my opinion made it more difficult to maintain services.

45. Detail the nature of your involvement with respect to communication with staff of the BAC about the possible (or actual) closure of the BAC. In particular, state when this communication occurred, what it involved and any input/decision you received with respect to the content of the communication (and from whom and when).

187. In response to question 45 I do not believe I had any specific involvement in relation to communications with BAC staff. From briefings through the CEDoHOC and from emails I received and referred to earlier in this statement I formed the view that the Chief Executive, WMHHS provided timely communications to staff.

188. In particular, on 3 October 2013, I received a copy of the BAC Communiqué 1 and Fast Fact Sheet (No. 8) that had been forwarded to Dr Kingswell from Dr Leanne Geppert. This information was provided as part of an update from Dr Kingswell where he understood that a meeting held that day with staff and patients and that Dr Kingswell had "gone very well".

46. Outline the extent and nature of your involvement in the placement of former staff of BAC as a consequence of BAC's closure, and any difficulties experienced or concerns raised with you (and any action taken by you as a result).

189. In response to question 46, I did not have involvement in the placement of former staff of BAC as a consequence of the BAC's closure.

190. I note that the transition arrangements for staff were noted at the CEDoHOC.

47. With respect to the Barrett School, outline the nature and extent of your involvement in meeting and/or communicating with staff or officers of the Department of Education or the Minister for Education (including when and the purpose and content of the communication, and any action taken by you as a result).

191. In response to question 47 I say that in March 2014, a meeting was requested by the Chief Executive WMHHS to clarify the arrangements that were in place within the Department of Education and the support that was being provided to previous clients of the BAC.

192. I met with the Deputy Director-General of the Department of Education, the Regional Director Department of Education, Dr Kingswell, Sharon Kelly and Lesley Dwyer. The Education representatives explained the arrangements that were in place. The Barrett School was now operating at Yeronga and continued to support some transition clients.

193.

194.

195. The Director-General of the Department of Education also raised with me concerns that teachers who supported Transition Clients of the BAC did not have confidence in the mental health services that their previous students accessed. Given these concerns and my belief that it was important that these teachers had confidence in the available mental health services, I organised for Professor David Crompton to meet with the teachers and detail how MSHHS respond to clinical issues. My

understanding was that Professor Crompton had indicated that the teachers were appreciative of the advice he gave and would refer any mental health concerns to the mental health services in MSHHS. The Director-General, Department of Education subsequently confirmed this.

Health Service Investigation

48. The Commission understands that on 14 August 2014, Associate Professor Beth Koetze, Ms Kristi Geddes and Ms Tania Skippen were appointed to conduct a health service investigation under section 190(1) of the Hospital and Health Boards Act 2011.
With respect to this investigation, to what extent were you involved in:
(a) the decision to commission the investigation and the key factors which led to it being commissioned;
(b) preparing the Instrument of Appointment under Part 9 of the Hospital and Health Boards Act 2011;
(c) preparing the Schedule annexed to the Instrument of Appointment, which outlined the scope of the investigation;
(d) selecting any or all of Associate Professor Beth Koetze, Ms Tania Skippen or Ms Kristi Geddes;
(e) setting the Terms of Reference for the investigation.

196. In response to question 48(a) I say that following the death of one of the Transition Clients, I convened an incident management team to review the matter and consider if any system level actions were required. One of the considerations was the effectiveness of transition planning for the transition clients.

197. I considered it important to ensure that the transition planning was comprehensive and effective and that there had been no gaps in the transition activities. I further considered that if there were gaps that the Department of Health and the relevant HHS's would need to take action to ensure that patients were receiving appropriate care and support. This could be ascertained through a Part 9 investigation under the *Health and Hospital Boards Act (2011) (HHB Act)*. The Director-General indicated his support for such an investigation under the HHB Act.

198. In response to questions 48(b) and 48(c) I say that the Department of Health has a standardised process for progressing these matters. There is a standard suite of documents used. However, a critical component of these documents is the Terms of Reference.

199. Ms Kirstine Sketcher-Baker, Senior Director, Patient Safety Unit, and the Chief Legal Council and officers from the Department of Health Legal Branch assisted in the preparation of the draft Terms of Reference in August 2014. The terms were settled by the Chief Legal Counsel endorsed by myself and approved by the Director-General.

200. In response to question 48(d) I say that I was not familiar with experts in this field. I requested that Dr Kingswell identify clinicians who could potentially undertake the review who were eminent and had expertise in adolescent mental health services. Dr Kingswell identified that Dr Beth Koetze and *Ms Tania Skippen as* potential persons who could undertake that work. A lawyer, Ms Kirstie Geddes, was also included in the review team on advice from the Chief Legal Council. The lawyer was drawn from one a legal firm on the Department of Health Legal Panel. The inclusion of a lawyer as a health service investigator ensured that the review team had appropriate logistic and legal supports.

201. In response to question 48(e), I say that on or about 14 August 2014, I reviewed the Brief recommending the Director-General approve the Terms of Reference and the investigators. The CVs of the proposed investigators were attached to the Briefing. Based on that information I considered Dr Koetze would be an appropriate person to lead the review based on this information.

49. The Commission understands that on or about 28 August 2014, you granted an extension for the provision of the investigation report. Provide details as to:
(a) the nature and level of your input into the selection of the timeframe for the delivery of the investigation report;
(b) the period in which the investigative report was initially required to be delivered (i.e. prior to any extension being granted); and
(c) the basis upon which the delivery date was selected, and the reason(s) why the report was required within that timeframe.

202. In response to question 49(a) I say sought the advice of the Chief Legal Counsel within the Department of Health with respect to what would be deemed to be a reasonable timeframe, taking into consideration the work required of the investigators and the volume of material they would need to review. The volume of material requiring review was larger than anticipated as was the number of witnesses that the investigators wished to interview.

203. The Chief Legal Counsel in the Department of Health and myself have had experience in assessing timeframes having been involved in all of the *HHB Act* Part 6 clinical or clinically related investigations since the *HHB Act* came into effect. I also understand that the Chief Legal Counsel confirmed her understanding of the timeframe and other requirements with Ms Kirstie Geddes.

204. In response to question 49(b), I say that the investigation report was to be provided to the Director-General by 16 September 2014.

205. The report was required within a timeframe so that the Department of Health could be confident in the transition planning and if there were gaps in the planning that these could be addressed.

50. The Commission understands that on or about 30 October 2014, Ms Geddes was advised that no further extensions for the production of the investigation report would be granted. Provide details as to:
(a) the truth or otherwise of this statement; and
(b) the reason(s) for the decision that no further extensions would be granted.

206. In response to question 50(a), I say that the statement is accurate. There had been an extension to 31 October 2014.

207. In response to question 50(b) as set out above, the Department of Health was concerned that there may have been inadequacies in the transition of clients and thus it was determined that it was necessary to receive the investigation report as soon as possible so that the Department of Health could respond to any potential deficiencies.

208. As outlined above the Chief Legal Counsel in the Department of Health and myself have had experience in assessing timeframes, having been involved in all of the *HHB Act* Part 6 clinical or clinically related investigations since the *HHB Act* came into effect. As the investigators had not identified additional materials that they would need to review and given that an extension had already been provided I believed that the review could be completed within this timeframe. I also understand that the Chief Legal Counsel conferred with Ms Kirstie Geddes who indicated that this timeframe was achievable.

51. Detail your understanding as to any limitations placed upon Associate Professor Koetze and/or Ms Skippen with respect to the scope of the investigation report and access to documents and/or witnesses/personnel (and the nature and basis for these limitations).

209. In response to question 51, I say that the investigation was a specific review of the transition arrangements. It was not intended as a broad review to look at other matters regarding the BAC. When the Department of Health was settling the Terms of Reference, the Department was conscious that Coronial investigations were already afoot and that the Coroner would be specifically examining the circumstances relating to the deaths of former clients of the BAC.

210. The scope of the investigation is outlined in the investigation report.

211. It should be noted that the deaths which occur where clients are under the care of HHS's can be reviewed internally by the health services. These reviews are described as Root Cause Analysis (RCA) and are authorised under the *HHB Act*. These types of reviews aim to identify issues and opportunities to improve the system of care provided to clients and patients so as to prevent similar occurrences in the future. HHS's also have the ability to undertake formal investigations under Part 6 of the *HHB Act*.

52. With respect to the investigation report, provide details as to:
(a) the date when you received the investigation report (including any draft(s));
(b) the purpose for which you received the investigation report; and
(c) any action taken by you as a consequence of the investigation report.

212. In response to question 52 (a) I say that the report was received on 31 October 2015. I did not receive a draft copy of the report.

213. In response to question 52(b), I received the report and reviewed it to determine if the transition planning was appropriate. A copy of the redacted version of the report is attached at **MIC-25**. I discussed the final report with the Director-General.

214. In response to question 52(c), I noted the investigation report and that the report made one recommendation.

215. This recommendation related to the development of policy guideline. I subsequently requested that Br Bill Kingswell action this recommendation. I am advised by Dr Kingswell that the recommendation has been action and closed.

216. I assisted with the communications both internally and externally following receipt of the report. This included ensuring that relevant families and staff were advised of the report being received and it's general findings prior to its formal release.

53. Outline the relationship (if any) between the investigation report and any investigation and/or correspondence received from the Office of the Health Ombudsman.

217. In response to question 53, I say that the Office of the Health Ombudsman separately commenced an investigation into the matter. This was subsequent to the Department of Health forwarding correspondence to the Office of Health Ombudsmen identifying that the Director-General was in receipt of the final

investigation report and offering to provide the Office of the Health Ombudsman with a complete copy if the requisite notice was issued.

Office of Health Ombudsman

54. The Commission understands that you in around 2014 - 2015, Queensland Health received and sent correspondence from/to the Office of the Health Ombudsman (OHO) which related to the BAC. With respect to this correspondence:
(a) provide details as to the circumstances in which the OHO contacted Queensland Health;
(b) provide details as to any complaint made to the OHO which led to the OHO contacting Queensland Health; and
(c) provide details as to the status of any investigation by the OHO (and, if applicable, the outcome of any investigation).

218. In response to question 54(a), I say that a letter was forwarded by the Director-General of the Department of Health to the Office of the Health Ombudsman on 5 November 2014 confirming that the Director-General was in receipt of the final investigation report. The letter identified that a redacted version would be the subject of limited release but that a full copy could be provided to the Ombudsman if the requisite notice was issued.

219. A letter was sent by the Health Ombudsman to the Department of Health on 18 November 2014 confirming that the matter had been brought to the Health Ombudsman's attention due to public concerns surrounding the BAC closure and the Health Ombudsmen had instigated an investigation pursuant to section 80(c) of the *Health Ombudsman Act 2013.* I signed a response which is attached at **MIC-26**.

220. In response to question 54(b), I am not aware of any complaint made to the OHO.

221. In response to question 54(c), on 27 August 2015, the Health Ombudsman forwarded a letter to the Director-General of the Department of Health confirming that the published terms for the Commission of Inquiry into the closure of the BAC suggest that the Commissioner will be inquiring into matters addressed in the Health Ombudsmen's draft report. The Health Ombudsman confirmed that no further action would be taken in relation to the matter, as it was being adequately dealt with by an appropriate entity.

Future Service Delivery

55. Provide details of any meetings, contact, telephone discussions, written communication and correspondence (including electronic) you had

regarding the future service delivery of mental health services to adolescents in Queensland who previously met the criteria for the delivery of services by the BAC (i.e. proposed service delivery in lieu of the BAC) and the date(s) when this occurred and with whom.

222. In response to question 55, I say that a number of new mental health services have been implemented across Queensland in the last 2 years. This is as a result of the model developed by CHQHHS known as the AMHETI, which recommends five key service elements, being:

(a) Statewide subacute beds;

(b) Day programs;

(c) Assertive mobile youth outreach services;

(d) Step up/step down units; and

(e) Residential rehabilitation units (Youth Resi).

223. As a result of this model, a range of new services have been implemented. These are outlined in my response to question 33.

224. In relation to the communications that I have had in regard to these matters this has been with Dr Kingswell at our regular monthly meeting and with Mr Nick Steel. These discussions were generally in relation to funding provided through Service Agreements with Hospital and Health Services. Documentation of these changes was by way of service agreement modifications. I have also approved financial or procurement arrangements for a range of service enhancements including the new residential rehabilitation units in Cairns and Townsville and the additional community teams that were deployed following the tragic deaths of 8 children in Cairns in December 2014.

56. Without limiting the above question, in relation to the future service delivery of mental health services to adolescents in Queensland who previously met the criteria for the delivery of services by the BAC (i.e. proposed service delivery in lieu of the BAC):

(a) what is Queensland Health's proposed model of service delivery for children and adolescents who previously met the criteria for admission at the BAC;

(b) were additional funds allocated to Child and Youth Mental Health Services (CYMHS) across Queensland upon the closure of the BAC. How much of the funding for the BAC was re-allocated to CYMHS across Queensland;

(c) what framework was developed for the delivery of non-specialist mental health care (i.e. support, care and community access) to adolescents in Queensland at risk and previously in need of a 'tier 3' service;

(d) were any agreements with non-government organisations entered into for the delivery of these services. If so, what organisations were contacted with a view to providing the delivery of these services. Were any agreements entered into with these organisations;

(e) was any training in the area of child and adolescent mental health offered, developed or provided to these non-government organisations;

(f) was any additional training offered, developed or provided for Queensland Health staff in relation to child and adolescent mental health issues upon closure of the BAC;

(g) were there any proposals or plans in place within Queensland Health for the development of a new adolescent extended treatment Tier 3 facility in place in lieu of the BAC;

(h) did you meet with anyone regarding the future delivery of child and adolescent mental health services with respect to the delivery of services previously offered by the BAC. If so, who did you meet with and what did you discuss. What were the outcomes of these meetings; and

(i) were any non-governmental residential rehabilitation service organisations contacted to provide additional services to at risk child and adolescents, was additional funding provided to these organisations, and what were the arrangements made with these organisations.

225. In response to question 56(a), I say that this is a question that the Chief Executive CHQHHSs who oversaw the development of the new service model would be better placed to answer.

226. In response to question 56(b), I say that I am not able to answer this question other than to refer to responses contained in this statement. The Chief Executive CHQHHS would be best placed to advise in relation to this question.

227. In response to question 56(c), I say that I an not able to answer this question other than to refer to responses contained in this statement. The Chief Executive CHQHHS would be best placed to advise in relation to this question.

228. In response to question 56(d), I say that there were a range of agreements entered into by both the Department of Health and relevant HHS's. The Executive Director MHAODB and the Chief Executive CHQHHS would be best placed to advise in relation to this question.

229. In response to question 56(e), I say that I am not able to answer this question as it would be specific to service agreements with individual NGO's. The Executive Director MHAODB and the Chief Executive CHQHHS would be best placed to advise in relation to this question.

230. In response to question 56(f), I say that I am not able to answer this question. The Chief Executive CHQHHS would be best placed to advise in relation to this question.

231. In response to question 56(g), I say that to my knowledge that there were no proposals or plans in place for the development of a Tier 3 facility in lieu of the BAC. Following the change of Government in 2015 the Department of Health commenced early scoping work for a facility should the construction of such a facility be a recommendation of the Commission.

232. In response to question 56(h), I say that I had regular monthly meetings with Dr Kingswell where service developments were discussed. Other meetings such as the CEDoAHOC which are relevant to this question are outlined elsewhere this statement.

233. In response to question 56(i), I say that there have been a number of non-government organisations contracted to provide additional services. These are outlined in my response to question 30. Additional funding was provided to these organisations. The Executive Director MHAODB and the Chief Executive CHQHHS would be best placed to provide the details of these arrangement.

57. The Commission understands that Queensland Health prepared a draft "Guideline on the transition of care for young people receiving mental health services". With respect to this Guideline, provide details as to:
(a) the date when work on the Guideline commenced;
(b) who was involved in the preparation of the Guideline;
(c) the relationship (if any) between the Guideline and:
(i) the decision not to proceed with the Redlands unit;
(ii) the closure of the BAC;
(iii) the decision to close the BAC by January 2014.
(d) the content of the Guideline; and
(e) the date of publication.

234. In response to question 57(a), I say that the date when work on the Guideline commenced was in February 2014.

235. In relation to question 57(b), I say that the Clinical Governance Team, Office of the Chief Psychiatrist was involved in the preparation of the Guideline. The Chief Psychiatrist is the custodian of the Guideline. I was not involved in the development of the Guideline.

236. In relation to question 57(c), I say that there is no relationship between the Guideline and the decision not to proceed with the Redlands unit, the closure of the BAC or the decision to close the BAC by January 2014. The Guideline was prepared as a response to the recommendation of the Health Service Investigation as outlined in my response to question 52.

237. A copy of Guideline to respond to (d) above is attached at **MIC-27**.

238. The Guideline was effective from 1 July 2015.

Other

58. Outline and elaborate upon any other information or knowledge (and the source of that knowledge) that you have relevant to the Commission's Term of Reference.

239. In response to question 58, I say that that to the best of my knowledge this statement addresses the matters relevant to the Commissions Terms of Reference that I can assist with.

.....

DR MICHAEL I CLEARY

Deponent / Witness

EXHIBIT 40

Dated: 21-12-15

Deponent

Witness

EXHIBIT 40

EXHIBIT LISTING

Bound and marked 'MIC-1' to MIC-27' are the exhibits to the Statement of **MICHAEL I CLEARY** dated 21 December 2015:

Exhibit	Document	Date	Page
MIC-1	Requirement to Give Information in a Written Statement Notice	11.11.15	1 - 23
MIC-2	Curriculum Vitae of Dr Michael I Cleary	Undated	24 - 26
MIC-3	Role description for Director-General, Queensland Health	11.08.15	27 - 30
MIC-4	Role description for Deputy Director-General Health Service and Clinical Innovation Division	Undated	31 - 35
MIC-5	Appointment letter to position of Chief Operations Officer, Department of Health and Deputy Director-General, Health Service and Clinical Innovation Division.	17.09.14	36 - 38
MIC-6	Role description for Deputy Director-General Clinical Excellence	07.08.15	39 - 42
MIC-7	Role Description Deputy Director-General Policy, Strategy and Resourcing	25.01.10	43 - 46
MIC-8	Terms of Reference for Budget Review Committee	18.07.12	47 - 49
MIC-9	Queensland Commission of audit Interim Report June 2012	15.06.12	50 - 265
MIC-10	Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019	Sept 2014	266 - 297
MIC-11	Fourth National Mental Health Plan - An agenda for collaborative government action in mental health 2009-2014	2009	298 - 385
MIC-12	Statewide Mental Health Alcohol and Other Drugs Clinical Network Terms of Reference 2012-13	Aug 2013	386 - 395
MIC-13	Briefing note for Noting re Barrett Adolescent Strategy Meeting	08.07.13	396 - 403
MIC-14	Briefing note for approval re approval to close Barrett	02.11.12	404 - 407
MIC-15	Memorandum from Lesley Dwyer Letter in response to Lesley Dwyer	04.12.12 13.12.12	408 - 410
MIC-16	Expert Clinical Reference Group Recommendations Barrett Adolescent Strategy July 2013 & Terms of Reference: Expert Clinical Reference Group - Barrett Adolescent Strategy	30.11.12	411 - 434

EXHIBIT 40

Exhibit	Document	Date	Page
MIC-17	Project Plan re Barrett Adolescent Strategy		435 – 449
MIC-18	Terms of Reference: Expert Clinical Reference Group – Barrett Adolescent Strategy	30.11.12	450 – 451
MIC-19	Adolescent Mental Health Extended Treatment Initiative Update (AMHETI)– November 2015	Nov 2015	452 – 453
MIC-20	Queensland Commission of Audit Final report – February 2013	Feb 2013	454 – 536
MIC-21	Memorandum from Peter Steer	26.09.13	537 – 538
MIC-22	Terms of Reference Chief Executive and Department of Health Oversight Committee	19.09.13	539 – 542
MIC-23	Email attaching Briefing Note for approval re Update on the Barrett Adolescent Centre	15.07.14	543 – 548
	Struck Out by the Commissioner on 25 February 2016		
MIC-25	Report: Transitional Care for Adolescent Patients of the Barrett Adolescent Centre (redacted)	30.10.14	555 – 566
MIC-26	Letter to Leon Atkinson-MacEwen, Health Ombudsman, from Dr Cleary	10.04.15	567 – 579
MIC-27	Guideline for the transition of care for young people receiving mental health services.	21.09.15	580 – 586

BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

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

REQUIREMENT TO GIVE INFORMATION IN A WRITTEN STATEMENT

To: Dr Michael Cleary

Of: c/- Crown Law via [redacted]

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

YOU MUST COMPLY WITH THIS REQUIREMENT BY:

Giving a written statement prepared either in affidavit form or verified as a statutory declaration under the *Oaths Act 1867* to the Commission before **Wednesday 2nd December 2015**, by delivering it to the Commission at Level 10, 179 North Quay, Brisbane.

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

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

DATED this 11th **day of** November **2015**

[redacted]

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

SCHEDULE

Background and experience

1. Outline your current professional role/s, qualifications and memberships. Please provide a copy of your current/most recent curriculum vitae.

2. The Commission understands that you hold (or have held) the positions of Director General Queensland Health (including in the capacity of A/Director General Queensland Health) and Deputy Director General Health Service and Clinical Innovation. With respect to each of these positions:

    a. state the period during which you held the position;

    b. outline your key responsibilities, including working and reporting relationships and the branches (or areas) which fell within your responsibility;

    c. detail your role and responsibilities with respect to the operation and/or management of the Barrett Adolescent Centre (**BAC**); and

    d. provide a copy of your position description.

3. Identify and provide details of all other positions and appointments (permanent, temporary or acting) held by you in Queensland Health for the financial years 2003 – 2014, which are not already detailed in response to question two above.

Replacement unit for the BAC

4. Outline the nature and extent of your involvement in the planning of the 15-Bed Adolescent Extended Mental Health Treatment Unit at Redlands Hospital (**the Redlands unit**). In particular:

    a. explain the nature and extent of your involvement, and the relevant date(s);

    b. provide details of the capital allocation to fund the Redlands unit;

    c. outline the nature and extent of your involvement (if any) in the 2004 report, "*Options Study for Barrett Adolescent Centre at The Park Centre*" and state the

date when you received this report (and from whom), and for what purpose, and what steps (if any) you took as an outcome of the study.

5. With respect to the plan to build the Redlands unit, outline:

   a. the genesis of the plan (and when it arose and the names and positions of those persons involved); and

   b. how far the planning of the Redlands unit progressed, prior to its cancellation.

6. Outline the nature and extent of your involvement in the decision to not proceed with the development of the Redlands unit. In particular:

   a. when was the decision made and by whom, and in what circumstances;

   b. identify who else had involvement and/or input into the decision;

   c. state the reason(s) why the Redlands unit did not proceed;

   d. explain the relevance (if any) of the "*Fiscal Repair Strategy*" on the decision;

   e. explain your knowledge of the redirection of the capital allocation (including by whom and to where and when).

7. Upon the decision being made not to proceed with the Redlands unit, explain whether:

   a. consideration was ever given to the following alternatives (and, if so, when and by whom and in what circumstances, and outline the reason(s) why/why not)):

      i. an alternative site for a Tier 3 service; and/or

      ii. refurbishment of the BAC; or

   b. a decision had already been made (and, if so, by whom and when) that a Tier 3 would not be developed and (if yes, the basis of that decision).

8. At the time when the decision was made not to proceed with the Redlands unit, who would have had authority to establish an alternative Tier 3 service (had this option been progressed and a location identified)?

9. Explain the relevance (if any) of the "*Queensland Plan for Mental Health 2007-2017*" with respect to:

   a. the genesis and development of the plan to construct the Redlands unit, and the cancellation of that plan; and

   b. consideration (or lack of consideration) of a replacement Tier 3 service at an alternative location.

Barrett Adolescent Centre (BAC)

10. The Commission understands that the BAC was referred to as being a 'Tier 3' service. Under what policy document or otherwise, was BAC classified as being a Tier 3 service (and provide a copy)?

11. With respect to the BAC:

   a. during financial years 2003 to 2014, how was the BAC funded (include detail of the nature of that funding, and any changes in financial responsibility throughout this period (and explain when those changes occurred and what they involved));

   b. how did the amount of funding required for the BAC compare as against that required for community care models of care;

   c. what were the financial implications for a state-wide facility being located within a Hospital and Health Service district and, in particular, within:

      i. the West Moreton Hospital and Health Service); and/or

      ii. the Metro South Hospital and Health Service (i.e. the Redlands unit).

12. The Commission understands that the BAC provided a statewide mental health service. Provide details as to:

   a. statewide service plans relevant to the BAC (and provide copies);

b. State and National policies, plans and protocols, relevant to the management and operation of the BAC (and provide copies);

c. the relationship between the BAC, the Hospital and Health Services and the Department of Health, including, but not limited to:

i. roles in relation to accountability, oversight and responsibility for the BAC;

ii. how statewide mental health services were developed and overseen by the Department of Health;

iii. how statewide mental health services were planned for and overseen by Queensland Health (and provide copies of any documented framework and/or planning documents which were in place between the financial years 2003 to 2014);

iv. the role of the Mental Health, Alcohol and Other Drugs Branch with respect to the BAC.

13. The Commission understands that a number of statewide clinical networks sit within Queensland Health, one of which is the Mental Health Clinical Network. Provide details as to:

a. the role and function of the Mental Health Clinical Network and, in particular, with respect to the BAC (prior to its closure);

b. the role of the Mental Health Clinical Network (and any other Clinical Networks) with respect to approving the model of care at BAC;

c. any concerns raised between financial years 2003 to 2014 with respect to the model of care at the BAC (and provide details as to by whom, when and what steps were taken (if any)); and

d. whether the Mental Health Clinical Network was responsible for approving (or otherwise having oversight over) the model of care in place at the BAC prior to

its closure (and if so, provide details as to the nature and extent of the approval and oversight).

14. The "*Queensland Plan for Mental Health 2007-2017*" refers to *"Core Mental Health Services"*. With respect to this plan, provide details as to:

    a. the criteria for being a *"core mental health service"*, and the implications of being (or not being) classified as a *"core mental health service"* (and provide copies of any applicable policy document(s)).;

    b. whether the BAC was a *"core mental health service"* and the reason(s) why/why not; and

    c. whether the BAC was considered to be *"hospital treatment"* based on the type of care provided (inpatient subacute bed-based intensive treatment and rehabilitation services), and the reason(s) why/why not (and provide copies of any applicable policy document(s)).

Closure of the BAC

15. Who had authority to approve the closure of the BAC and by what means (and what was the basis of that authority)?

16. Who made the decision to close the BAC (and on what date, and by what means, and in what circumstances)?

17. Explain the extent of your involvement and/or input into the decision to close the BAC. In the event that you had direct involvement and/or input into the decision to close the BAC, provide details as to:

    a. the extent and/or nature of your involvement and/or input into the decision;

    b. the name and position of those other persons involved in the decision (and the nature and extent of their involvement);

    c. the reason(s) for the decision to close the BAC;

d. any consultation with experts and/or stakeholders (and when), and the nature of the consultation;

e. what advice/views were given by those experts and stakeholders prior to the decision, and how influential each of the perspectives was to the decision-making and/or your input into the decision to close the BAC;

f. all alternative options and/or service models considered in making and/or having input into the decision to close the BAC, and the reason(s) as to which were or were not accepted and/or implemented (and the reason(s) why);

g. your understanding (and the source of that understanding) as to the date when alternative options and/or service models would be available to former patients of the BAC) (and what those alternative options were);

h. whether an alternative Tier 3 service ever formed part of the decision-making process with respect to the closure of the BAC (and if so, when), and the reason why an alternative Tier 3 service was not established;

i. all meetings, contact, telephone discussions, written communication and correspondence (including electronic) you had regarding the decision to close the BAC (and detail with whom and when, and for what purpose); and

j. your knowledge of the redirection of the BAC's funding (including by whom and to where and when).

18. In the event you did not have direct involvement and/or input into the decision to close the BAC:

a. on what date, how and from whom, did you become aware of the decision to close the BAC;

b. detail your understanding as to the reason(s) for the decision to close the BAC (and the source of that understanding and how and when it was obtained);

c. outline your views as to the appropriateness of the decision to close the BAC;

d. how, when and to whom, you communicated the decision as to the closure of the BAC, and for what purpose;

e. provide details of all meetings, contact, telephone discussions, written communication and correspondence (including electronic) you had regarding the decision to close the BAC (and detail with whom and when, and for what purpose); and

f. explain your knowledge (if any) of the redirection of BAC's funding (including by whom and to where and when).

19. Outline the nature and extent of your involvement and/or input into the decision that the closure date for the BAC was to be January 2014. In the event you had direct involvement and/or input into the decision that the closure date for the BAC was to be January 2014, detail:

a. the extent and/or nature of your involvement and/or input into the decision and the names and positions of those other persons involved in making the decision;

b. the reason(s) as to why January 2014 was chosen for the closure of BAC;

c. on what date the decision as to the closure date was made;

d. any consultation with experts and/or stakeholders (and when), and the nature of the consultation;

e. what advice/views were given by those experts and stakeholders prior to the decision, and how influential each of the perspectives was to your decision-making and/or input into the decision;

f. the existence of any flexibility with respect to the January 2014 closure date, once set, or any review mechanisms; and

g. how, when and to whom, you communicated the decision as to the closure date (and for what purpose).

20. In the event you did not have any direct involvement and/or input into the decision that the BAC's closure date was to be January 2014:

    a. on what date, how and from whom, did you become aware of the decision that the closure date would be January 2014;

    b. any reason(s) communicated to you as to the reason for the closure date and from whom, by what means, and on what date; and

    c. the extent to which you were aware of the existence of any flexibility with respect to the closure date or any review mechanisms (and the source of that understanding).

21. Did you consider the January 2014 closure date to be appropriate and outline the reason(s) as to why/why not?

22. Did you facilitate or attend any meetings regarding the closure of the BAC and, if so, with whom and on what date(s), and for what purpose?

23. Detail any processes that you were involved in (or were otherwise aware of), with respect to communicating the closure decision to parents of BAC patients (and their families) and BAC staff, and the nature of your involvement (and when).

24. Explain the relevance (if any) of the "*Queensland Plan for Mental Health 2007-2017*" to:

    a. the initial plan to decommission the BAC and build the Redlands unit;

    b. the decision not to proceed with the Redlands unit;

    c. the decision to close the BAC;

    d. the decision to close the BAC by January 2014; and

    e. the decision to announce the closure of the BAC on 6 August 2013.

25. Explain the relevance (if any) of the redevelopment of The Park as an adult forensic facility and/or the opening of the EFTRU facility, to:

a. the initial plan to decommission the BAC and build the Redlands unit;

b. the decision to not proceed with the Redlands unit;

c. the decision to close the BAC;

d. the decision to close the BAC by January 2014; and

e. the decision to announce the closure of the BAC on 6 August 2013.

26. The Commission understands that the decision to close the BAC was announced by the former Health Minister on 6 August 2013 during an interview with the media. Explain:

a. the circumstances in which it was decided that the Health Minister would make the announcement on this particular date and via a media interview; and

b. the reason(s) as to why the decision to close the BAC was announced on 6 August 2013 (as opposed to some other date), including but not limited to, the relevance (if any) of the opening of the EFTRU.

27. Explain the relevance (if any) of the "*National Mental Health Service Planning Framework*" on decisions made with respect to the Redlands unit and/or the BAC, and state whether you received a copy of the framework (and from whom, on what date, and for what purpose) (and provide a copy).

Working Groups/Committees

28. The Commission understands that in around November 2012, an Expert Clinical Reference Group (**ECRG**) was formed to make recommendations with respect to models of care for mental health treatment and rehabilitation for adolescents in Queensland. With respect to the ECRG:

a. outline the nature and extent of your involvement in the formation of the ECRG, including but not limited to, the selection of its members (and the basis for their selection);

b. outline the nature and extent of your involvement in the functions of the ECRG. In particular, provide details as to:

i. your understanding as to the function of the ECRG and the report to be prepared by the ECRG;

ii. the development of the Terms of Reference, the scope and functions of the ECRG and the material to be considered by the ECRG;

iii. any input or direction given by you (or on your behalf) to the ECRG (or its members);

iv. any consultation by you (or carried out on your behalf) with the ECRG (or its members); and

v. any oversight and/or monitoring role which you played with respect to the ECRG.

c. provide details as to your understanding of the purpose of the ECRG and, in particular, the relationship between the ECRG and the Barrett Adolescent Strategy Project Plan (as prepared by West Moreton Hospital and Health Service);

d. Did you receive a copy of the ECRG report and, if so, when and how, and what action did you take.

29. Outline your views in respect of each of the recommendations made by the ECRG in its report.

30. In its report, the ECRG found inpatient extended treatment and rehabilitation care (tier 3) to be an essential service component. The ECRG further found that "*interim service provision if BAC closes and Tier 3 is not available is associated with risk*". With respect to these findings by the ECRG, outline:

a. whether the option of a tier 3 service was ever reconsidered/revisited, following receipt of this recommendation by the ECRG (and the reasons why/why not);

b. in the event the option of a tier 3 service was reconsidered/revisited, the nature of that consideration, who was involved and when;

c. the reason(s) why a tier 3 service was not developed or implemented, given the findings of the ECRG that tier 3 was an essential service component;

d. your views in respect of the risk identified by the ECRG, and any steps or actions taken by you as a consequence of this risk/to address this risk, in circumstances where a tier 3 service was not developed.

31. The Commission understands that on 18 March 2013 you received an email from Ms Sharon Kelly, requesting an urgent meeting that afternoon to discuss the *"ramifications"* for Queensland Health of the service model proposed by the ECRG. With respect to Ms Kelly's email, and the meeting on 18 March 2013:

a. provide details as to the matters discussed at that meeting including, but not limited to, any discussion about the inclusion by the ECRG of a tier 3 model in its recommendations;

b. provide details as to what were the *"ramifications"* referred to by Ms Kelly in her email; and

c. provide details as to the outcome of the discussion and any decisions made/action taken following the meeting (and when and by whom).

32. The Commission understands that the ECRG was overseen by a Planning Group. With respect to the Planning Group:

a. outline the nature and extent of your involvement with respect to the formation of the Planning Group and the selection of its members;

b. outline the nature and extent of your involvement in the functions of the Planning Group. In particular, provide details as to:

i. the development of any Terms of Reference, the scope and functions of the Planning Group and the material to be considered by the Planning Group;

ii. any input or direction given by you (or on your behalf) to the Planning Group (or its members);

iii. any consultation by you (or carried out on your behalf) with the Planning Group (or its members); and

iv. any oversight and/or monitoring role which you played with respect to the Planning Group,

c. state when you received a copy of the Planning Group report and outline by what means and for what purpose (and any steps taken by you as a result);

d. outline your views in respect of each of the recommendations made by the Planning Group.

33. As noted above, in its report, the ECRG found a tier 3 to be *"an essential service component"* and recommended that a tier 3 be prioritised. In its report, the Planning Group accepted this recommendation by the ECRG *"with considerations"*. These considerations were described as follows:

> *Further work is needed to detail the service model for a Tier 3. Models involving a statewide, clinical bed-based service (such as the Barrett Adolescent Centre) are not considered contemporary within the National Mental Health Service Planning Framework (in draft). However, there are alternative bed-based models involving clinical and non-clinical service components (e.g., Y-PARC in Victoria) that can be developed in Queensland to meet the requirement of this recommendation. Contestability reforms in Queensland may allow for this service component to be provider agonstic.*

With respect to the above extract, outline:

a. what further work (if any) has been undertaken in Queensland *"to detail the service model for a tier 3"* (and provide details as to when and by whom and the status of that work);

b. whether you consider a statewide, clinical bed-based service to be contemporary within the National Mental Health Service Planning Framework and the reason(s) why/why not;

c. any steps taken to develop and/or implement alternative bed-based models involving clinical and non-clinical service components such as, but not limited to, Y-PARC (and provide details as to when and by whom and the status); and

d. your understanding of the meaning of: "Contestability reforms in Queensland may allow for this service component to be provider agnostic".

34. In its report, the ECRG found *"interim service provision if BAC closes and Tier 3 is not available is associated with risk"*. With respect to this finding, the ECRG recommended (together with other matters) that *"safe, high quality service provision for adolescents requiring extended treatment and rehabilitation requires a Tier 3 service alternative to be available in a timely manner if BAC is closed"*. The Planning Group's recommendation with respect to the ECRG's recommendation was - *"Accept"*. With respect to these matters, outline:

a. what are the *"safe, high quality services"* for *"adolescents requiring extended treatment and rehabilitation"* which are an alternative to a Tier 3 service (and provide details as to when they were implemented and what they involve); and

b. the basis upon which the alternative was assessed as being a *"safe, high quality"* service (and by whom and by what means, and what it involves).

35. Provide details of any other committees or groups you were a member of, or had involvement or input into the formation of, with respect to the operation and/or closure of the BAC, the option of the Redlands unit, and/or the development or implementation of AETR service options.

36. The Commission understands that the following working groups/committees were in existence at around the time when decisions were being made within Queensland Health with respect to the BAC:

a. Barrett Adolescent Centre Strategy Planning Group;

b. The Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy Steering Committee;

c. Chief Executive and Department of Health Oversight Committee;

d. Service Option Implementation Working Group;

e. Barrett Adolescent Centre Consumer Transition Working Group;

f. Financial and Workforce Planning Working Group; and

g. Young People's Extended Treatment and Rehabilitation Initiative (YPETRI) Governance Committee.

With respect to each of these groups/committees (and any other groups/committees of which you are aware, which concerned the BAC), provide details as to:

a. the role and function of the group (both generally and also in respect of the BAC specifically);

b. the circumstances and purpose for which each was established (and by whom and the period for which they operated; and

c. the nature and extent of your involvement and/or input (and when).

Transition Arrangements

37. The Commission is aware that during 2013 up until early 2014, a number of BAC patients were transitioned to alternative care arrangements. With respect to the Transition Clients:

a. who was responsible for developing the transition arrangements for the Transition Clients, and what were those transition arrangements;

b. who had the monitoring or oversight role for the transition arrangements for the Transition Clients;

c. provide details as to how transition arrangements were developed, including but not limited to, any consultation(s) with Transition Clients and/or their families, friends or carers (and the date and detail of such consultation(s));

d. outline the nature and extent of your role with respect to Transition Clients. In particular, detail your involvement in developing, managing and implementing transition arrangements (including, but not limited to, identifying, assessing and planning for care, support, service quality and safety risks);

e. what feedback or advice did you receive (and from whom and when) in relation to the progression of the transitioning arrangements for the Transition Clients;

f. did you meet with any of the BAC transition clients or their families / carers in relation to their transition from the BAC and, if so, when and for what purpose;

d. advise whether there were any transition plans to review the transition arrangements and outline what such review involved (and when and how it occurred).

38. Did you have any discussions with the medical or other staff at receiving alternative services regarding the Transition Clients' transitional arrangements, transition plans, treatment plans, clinical and educational needs or other matters? If so, explain the nature of these discussions, including the date on which they occurred, with whom and for what purpose.

39. Were you aware of any concerns regarding the transition of any Transition Clients from the BAC to an alternative service provider? If so:

a. detail any such concerns;

b. if there were concerns, state who were these concerns expressed by and to whom;

c. on what date and by what means did you become aware of these concerns; and

d. what steps, if any, did you cause to be undertaken as a result of any such concerns.

40. The Commission understands that you were (or are) a member of the Chief Executive and Department of Health Oversight Committee. With respect to this Committee:

a. state the period during which you were a member;

b. outline your role and responsibilities, and state who else was a member;

c. outline the function and responsibilities of the Committee with respect to the BAC including, but not limited to:

i. the decision to close the BAC;

ii. the date for closure of the BAC;

iii. the BAC School;

iv. staff of BAC and the BAC School;

v. the arrangements made for Transition Clients; and

vi. the development and implementation of service options.

41. Provide details of any meetings, contact, telephone discussions, written communication and correspondence (including electronic) you had regarding the treatment and care plans, including the ongoing health and wellbeing of the Transition Clients after the closure of the BAC. In particular:

a. did you meet with any of the Transition Clients or their families/carers? If so, who did you meet and what was discussed;

b. did you receive any advice or feedback into the transition arrangements for the Transition Clients after the closure of the BAC? If so, what advice or feedback did you receive; and

c. did you receive any advice as to the treatment or care plans for the Transition Clients?

BAC Staff

42. Explain the nature and extent of your involvement in the decision to stand down Dr Trevor Sadler. In particular, outline:

a. the nature of your involvement in the decision to stand down Dr Sadler;

b. on what date you first became aware of the matters the subject of the decision to stand down Dr Sadler, and from whom and by what means, and for what purpose;

c. the reason(s) why Dr Sadler was stood down.

43. Explain the extent of your involvement in the decision to appoint Dr Anne Brennan to the BAC. In particular, outline the extent of your involvement in:

a. the decision to appoint Dr Brennan (and the date when this decision was made and by whom and in what circumstances); and

b. providing briefing(s) to Dr Brennan with respect to her role at BAC (and the content of that instruction).

44. Provide details of any concerns held by you, or raised with you, in respect of staffing of the BAC, during the period 6 August 2013 until the closure of the BAC in January 2014 (and state any action taken by you as a result).

45. Detail the nature of your involvement with respect to communication with staff of the BAC about the possible (or actual) closure of the BAC. In particular, state when this communication occurred, what it involved and any input/decision you received with respect to the content of the communication (and from whom and when).

46. Outline the extent and nature of your involvement in the placement of former staff of BAC as a consequence of BAC's closure, and any difficulties experienced or concerns raised with you (and any action taken by you as a result).

47. With respect to the Barrett School, outline the nature and extent of your involvement in meeting and/or communicating with staff or officers of the Department of Education or the Minister for Education (including when and the purpose and content of the communication, and any action taken by you as a result).

Health Service Investigation

48. The Commission understands that on 14 August 2014, Associate Professor Beth Koetze, Ms Kristi Geddes and Ms Tania Skippen were appointed to conduct a health service investigation under section 190(1) of the *Hospital and Health Boards Act 2011*. With respect to this investigation, to what extent were you involved in:

a. the decision to commission the investigation and the key factors which led to it being commissioned;

b. preparing the Instrument of Appointment under Part 9 of the *Hospital and Health Boards Act 2011*;

c. preparing the Schedule annexed to the Instrument of Appointment, which outlined the scope of the investigation;

d. selecting any or all of Associate Professor Beth Koetze, Ms Tania Skippen or Ms Kristi Geddes;

e. setting the Terms of Reference for the investigation.

49. The Commission understands that on or about 28 August 2014, you granted an extension for the provision of the investigation report. Provide details as to:

a. the nature and level of your input into the selection of the timeframe for the delivery of the investigation report;

b. the period in which the investigative report was initially required to be delivered (i.e. prior to any extension being granted); and

c. the basis upon which the delivery date was selected, and the reason(s) why the report was required within that timeframe.

50. The Commission understands that on or about 30 October 2014, Ms Geddes was advised that no further extensions for the production of the investigation report would be granted. Provide details as to:

a. the truth or otherwise of this statement; and

b. the reason(s) for the decision that no further extensions would be granted.

51. Detail your understanding as to any limitations placed upon Associate Professor Koetze and/or Ms Skippen with respect to the scope of the investigation report and access to documents and/or witnesses/personnel (and the nature and basis for these limitations).

52. With respect to the investigation report, provide details as to:

a. the date when you received the investigation report (including any draft(s));

b. the purpose for which you received the investigation report; and

c. any action taken by you as a consequence of the investigation report.

53. Outline the relationship (if any) between the investigation report and any investigation and/or correspondence received from the Office of the Health Ombudsman.

Office of Health Ombudsman

54. The Commission understands that you in around 2014 – 2015, Queensland Health received and sent correspondence from/to the Office of the Health Ombudsman (**OHO**) which related to the BAC. With respect to this correspondence:

a. provide details as to the circumstances in which the OHO contacted Queensland Health;

b. provide details as to any complaint made to the OHO which led to the OHO contacting Queensland Health; and

c. provide details as to the status of any investigation by the OHO (and, if applicable, the outcome of any investigation).

Future Service Delivery

55. Provide details of any meetings, contact, telephone discussions, written communication and correspondence (including electronic) you had regarding the future service delivery of mental health services to adolescents in Queensland who previously met the criteria for the delivery of services by the BAC (i.e. proposed service delivery in lieu of the BAC) and the date(s) when this occurred and with whom.

56. Without limiting the above question, in relation to the future service delivery of mental health services to adolescents in Queensland who previously met the criteria for the delivery of services by the BAC (i.e. proposed service delivery in lieu of the BAC):

a. what is Queensland Health's proposed model of service delivery for children and adolescents who previously met the criteria for admission at the BAC;

b. were additional funds allocated to Child and Youth Mental Health Services (**CYMHS**) across Queensland upon the closure of the BAC. How much of the funding for the BAC was re-allocated to CYMHS across Queensland;

c. what framework was developed for the delivery of non-specialist mental health care (i.e. support, care and community access) to adolescents in Queensland at risk and previously in need of a 'tier 3' service;

d. were any agreements with non-government organisations entered into for the delivery of these services. If so, what organisations were contacted with a view to providing the delivery of these services. Were any agreements entered into with these organisations;

e. was any training in the area of child and adolescent mental health offered, developed or provided to these non-government organisations;

f. was any additional training offered, developed or provided for Queensland Health staff in relation to child and adolescent mental health issues upon closure of the BAC;

g. were there any proposals or plans in place within Queensland Health for the development of a new adolescent extended treatment Tier 3 facility in place in lieu of the BAC;

h. did you meet with anyone regarding the future delivery of child and adolescent mental health services with respect to the delivery of services previously offered by the BAC. If so, who did you meet with and what did you discuss. What were the outcomes of these meetings; and

i. were any non-governmental residential rehabilitation service organisations contacted to provide additional services to at risk child and adolescents, was additional funding provided to these organisations, and what were the arrangements made with these organisations.

57. The Commission understands that Queensland Health prepared a draft "*Guideline on the transition of care for young people receiving mental health services*". With respect to this Guideline, provide details as to:

a. the date when work on the Guideline commenced;

b. who was involved in the preparation of the Guideline;

c. the relationship (if any) between the Guideline and:

a. the decision not to proceed with the Redlands unit;

b. the closure of the BAC;

c. the decision to close the BAC by January 2014.

d. the content of the Guideline; and

e. the date of publication.

Other

58. Outline and elaborate upon any other information or knowledge (and the source of that knowledge) that you have relevant to the Commission's Term of Reference.

59. Identify and exhibit all documents in your custody or control that are referred to in your witness statement.

EXHIBIT 40

Dr Michael I. Cleary

Associate Professor of Medicine

Executive Professional Profile

Visionary and results-driven senior executive offering over 30 years of experience and achievements in health care, medical and corporate industries. Respected and experienced leader, strategic planner and specialist at identifying and capturing business opportunities, leading transformational change and delivering organisational performance. A problem solver and decision maker who has delivered on government commitments through the management of complex healthcare systems, health policy development, medical administration and emergency medicine.

Selected Achievements

- Driven innovation programs and health system performance, resulting in improved services and outcomes for Queensland patients
- Advisor to the Queensland Premier and Queensland Minister for Health on professional and organisational aspects of Queensland's health system
- Commissioned the independent Hunter Review to ensure alignment of Queensland's Department of Health activity to an operating system where Hospital and Health Services (HHSs) have been transferred accountability for the delivery of public sector health services
- Key note speaker at state, national and international conferences in areas of health reform, trauma care, aeromedical services, Indigenous health, information systems, emergency department triage, disaster management, casemix systems, output based funding, elective and day surgery, clinical benchmarking, medical imaging, rehabilitation medico-legal matters and incident management
- National Board and Committee member across multiple Australasian Medical organisations and associations
- Authored papers, abstracts and reports across an extensive array of medical and corporate journals and publications
- Awarded the Australian Government Public Service Medal for outstanding public service to healthcare innovation improvement and reform in Queensland (2014 Australia Day Awards)
- Recipient of Buchanan Prize (Australasian College for Emergency Medicine), Challenge Award (Royal Australasian College of Medical Administrators), Premiers Award for Excellence 2001, Director-General's Special Commendation 2000 and Queensland Health Excellence Award 1999, RACMA Challenge Award Medallion 1993
- Pre-Eminent Staff Specialist, Queensland Health 1999
- Colonel in the Australian Defence Force
- Various Honorary and Teaching appointments.

Professional Qualifications

- Fellow of Royal Australasian College of Medical Administrators I 2009
- Instructor, Care of the Critically Ill Surgical Patient I 2001 (Previous)
- Instructor, Pre Hospital Trauma Life Support Course I 1998 (Previous)
- Certificate in Disaster Medicine I Emergency Management Institute I 1994
- Master of Health Administration I University of New South Wales I 1993
- Associate Fellow of the Australian College of Health Services Executives I 1993
- Instructor, Early Management of Severe Trauma Course I 1990 (Previous)
- Fellow of the Australasian College for Emergency Medicine I 1989
- ~~Royal Australasian College of Surgeons I Part One examination I 1987~~
- Bachelor of Medicine, Bachelor of Surgery I University of Queensland I 1983.

Specialist Skills

- Expert leader of significant health reform within the public service and specialist advisor on health service, professional practice, leadership, clinical innovation and contemporary practice
- Expert knowledge of emergency medicine, medical administration and health policy development
- Leader in organisational transformation, change management and organisational health, values and culture
- Leadership, direction, support and professional development for a large group of specialist health sector professionals
- Strategic leader in planning, implementation, governance and performance management in a range of health care, clinical and corporate environments
- Leader of state-wide portfolio operations ensuring optimal levels of service within budget parameters.