IN THE MATTER OF THE COMMISSIONS INQUIRY ACT 1950

COMMISSIONS OF INQUIRY ORDER (No. 4) 2015

BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

Submissions on behalf of Dr Trevor Sadler

1. These submissions are made on behalf of Dr Trevor Sadler, psychiatrist. He occupied the positions of Acting Medical Director of the Barrett Adolescent Centre (**BAC)** between 1986 and 1995 and Business Unit Director between 1995 and the latter 2000s. He was thereafter referred to as the Medical Director or Clinical Director of the BAC until 10 September 2013. He has extensive experience in adolescent mental health, in both the inpatient and community settings.

2. Leave was granted on 30 September 2015 for Dr Sadler to be legally represented. These submissions are limited to those issues which are relevant to Dr Sadler's interests.

Bases for closure decision of BAC - 6 August 2013

3. In light of the detailed submissions of Counsel Assisting, the only issue considered below is whether a lack of clinical governance was a reason for closure. The weight of the evidences establishes that it was not. Counsel Assisting's submissions at paragraphs 264-266 are adopted and relied on in this regard.

4. There are further pertinent points to be made.

5. The decision to close the BAC was communicated by the Mental Health Alcohol and Other Drugs Branch (**MHAODB**) to Ms Kelly at a meeting on 25 October 2012. The reasons did not relate to clinical governance issues.[1]

6. Prior to the announcement of the closure decision, there were numerous documents created relevant to the decision to close. These included Agenda Papers for the WMHHS Board meetings, Minutes of the WMHHS Board meetings, Briefing Notes to the Director-General and Briefing Notes to the then Minister for Health. In none of these documents are clinical governance issues raised as a reason for closing the BAC.

7. On 2 November 2012, Sharon Kelly met with Drs Sadler and Stedman to inform them that the BAC would be closing. On 5 or 6 August 2013, Lesley Dwyer met with Dr Sadler and Nurse Clayworth to inform them that the BAC would be closing in early 2014. One would have thought that if clinical governance had been one of the reasons for closure, Ms Kelly and Ms Dwyer would have raised this with Dr Sadler at their respective meetings. They did not.

8. Ms Kelly was requested by the Commission to address a number of issues in a statutory declaration. One of these issues was *'the reasons for the decision to close BAC'*. In

[1] Exhibit 66, para 9.2-9.8 & 'SK-9'

response to this request, Ms Kelly relevantly stated *'From my perspective …..., the reasons for closure were….'*. She provided three reasons, none of which relate to clinical governance concerns.[2]

9. Ms Dwyer, was also requested by the Commission to address a number of issues in a statutory declaration. One of these was *'any concerns Ms Dwyer had about the BAC'*. In response to this request, Ms Dwyer raised her concerns regarding the physical aspects of the BAC building, the proximity of the BAC to The Park adult mental health services, that the BAC was not consistent with contemporary models of community linked care and staffing issues which seemed to be associated with the fact that it was well known that the BAC was to close when the Redlands facility was ready to open. Once again, none of Ms Dwyer's concerns relate to clinical governance issues at the BAC.[3]

10. These matters only require consideration if the Commission concludes, contrary to the submissions above and to those of Counsel Assisting, that clinical governance related issues were one of the reasons for the decision to close the BAC.

11. Senior Counsel for WMHSS robustly questioned Dr Sadler regarding the incidents for the purpose of establishing that Dr Sadler's management of them pointed to a failure of clinical governance. The failure is purported to stem from Dr Sadler's clinical judgment in not making mandatory reports in relation to with respect to the behaviours of other young people at the BAC towards on 30 July 2013 and 3 September 2013.

12. These incidents are the subject of analysis at paragraphs 348 to 351 and paragraph 443 of Counsel Assisting's submissions. It is accurate that the Investigation Report contains far more details of the concerns when compared to the information that was on hand at the time Dr Sadler was This is in circumstances where it was not until 10 September 2013 (by which time Dr Sadler had already been , that provided detailed statements to the investigator.[4] The more limited information known by WMHHS executive prior to this time can be found in the handwritten file notes of Dr Geppert and Ms Kelly made in early September 2013.[5]

13. In any event, the conclusion contented for on behalf of WMHHS in relation to Dr Sadler's management of the does not find support in the evidence. Dr Sadler had been treating psychiatrist for some 12 months. From May 2013, he had been seeing two to three times per week in a treatment context. He knew well and was mindful of his reporting obligations. Dr Sadler provided cogent evidence as to why he did not consider either incident reached the

[2] Exhibit 66, para 11.1
[3] Exhibit 49, in partic para 5.17-5.20
[4] Exhibit 66, 'SK-5'
[5] Exhibit 55, 'LG-16; Exhibit 66 at 'SK-34'

threshold test of 'significant harm' to [redacted] to trigger Dr Sadler's mandatory reporting obligations pursuant to the *Public Health Act* 2005.

14. It is noteworthy that Dr Kingswell had understood that it was not in issue that [redacted] had been [redacted] in the manner he asserted, on [redacted][6] This is not correct.[7] Further, Ms Kelly explained in evidence that the decision to [redacted] was made after she heard that Dr Sadler had apparently indicated that he would continue treating [redacted] in the inpatient unit at the Mater.[8] Dr Kingswell was not aware of this[9] and for reasons which are not clear, Ms Kelly did not speak with Dr Sadler about this. It is clear from Dr Sadler's most recent statement that he did not ever give such an indication. It would seem unlikely given he did not even work in the inpatient unit at the Mater at that time.[10]

15. Further, in evidence Ms Kelly explained that around approximately April 2013, she held concerns that the number of PRIMES being reported were more than would have been anticipated. She was also concerned that staff members had taken some of the young people to M15+ movies and another staff member had taken some of the young people out to get body piercings.

16. There is no evidence that the number of PRIMES being reported around this time was in fact higher. Further, it is pure speculation that any increase could be explained by a lack of clinical governance. An alternative explanation for an increase could well be the uncertainty created for the young people after it became known that the Redlands project had been cancelled and the BAC would be closing. This was in circumstances where the young people were not provided with any certainty as to when this was to occur or the services which were to be available to replace the BAC. Another potential explanation is that any increase may have been contributed to by the unexpected departure of Ms Georgia Watkins-Allen at short notice.

17. As to the staff members who had taken the young people to M15+ movies and to get body piercings, they were nursing staff for which Dr Sadler had no direct supervision over. Responsibility for their conduct lay with WMHHS through the nursing hierarchy at The Park. Dr Sadler was not aware of the intended outings and would not have approved of them if he had known they were being proposed. It was not until after the Commission commenced that Dr Sadler even became aware that a nursing staff member had taken some young people out for body piercings.[11]

BAC model of care and sub cohort

18. It is agreed with Counsel Assisting that the merits of the BAC as a health service for young people with mental illnesses is of questionable relevance. For this reason, a detailed analysis of it is not required. However, there are a few matters which are

[6] Transcript of proceedings, Day 13 , p. 13-50, ln 25-28
[7] Transcript of proceedings, Day 24 , p. 24-19, ln 1-7
[8] Transcript of proceedings, Day 11, p. 11-45
[9] Transcript of proceedings, Day 13, p. 13-51, ln 38-40
[10] Exhibit 254
[11] Transcript of proceedings, Day 24, p. 24-13, ln 25-44; p. 24-24, ln 1-3

addressed below, should they sought to be relied on as shortcomings which prompted the closure decision.

19. It is beyond dispute that the length of stay for some of the young people at BAC was longer than would have been ideal. Dr Sadler shared this concern. He explained in his first statement, that up until 2011, the average length of stay was approximately nine months. In paragraph 136 of the statement he detailed the factors which he considered impacted on transitioning young people out of the BAC at an earlier time than could be achieved. These included the sub-optimal physical layout of the facility; the lack of staff with skills in art, music, sand play and family therapy; and the lack of available step-down accommodation.[12] Dr Brennan addressed the last mentioned of these in her oral evidence in the following way:

> … I was aware of several services, but I think the services that we found very difficult to identify were accommodation services, and I guess I would say, from my experience particularly in private practice, child and adolescent psychiatry, but also preceding that, public – adult psychiatry, the resources in our society for anyone with a mental illness requiring supported accommodation are extremely limited, and the accommodation that is available, in my opinion, is extremely poor. And I think this has been the case for many years, at least since the early 1990s, and I'm also aware from colleagues' experience with their own children with very serious mental illness that it has been extremely difficult to source appropriate supported accommodation, publically or privately, even with a lot of effort going into that on a personalised basis. So to then be confronted with children in a public system requiring accommodation that needed to be funded and that was adequately resources was difficult. It was particularly difficult with this cohort, the ones needing the accommodation, because of their ages…[13]

20. There are references in the evidence to the fact that the BAC model was not an evidenced based model of care. Professors McDermott and Martin gave evidence of the paucity of evidence-based outcome research to support many mental health treatment programs.[14] They talked of the particular significant challenges in collating such research for the very small sub-cohort of young people who were treated at the BAC.[15] Dr Fryer agreed with their evidence on this point. She explained that it remains the case that there is still no evidence-based research to support community based treatment over extended inpatient treatment for the BAC sub-cohort, or vice versa.[16]

21. Dr Sadler explained in significant detail in his initial statement the models of intervention, treatment and rehabilitation used at the BAC (**the interventions**), the application of evidence based practice to the interventions and the steps taken by him to attempt to evaluate the BAC model of care, including the interventions.[17] This is against a background of Dr Sadler having visited in 2010 and 2011, at his own expense,

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[12] Exhibit 112
[13] Transcript of proceedings, Day 20, p. 20-23, ln 43-47 to 20-24, ln 1-12
[14] Transcript of proceedings, Day 25 , p. 25-31 to 25-33
[15] Transcript of proceedings, Day 19, p. 19-49, ln 31-43; Day 24, p. 24-55, ln 12-20; Day 25, p. 25-11, ln 1-35
[16] Transcript of proceedings, Day 25, p. 25-11, ln 1-35
[17] Ex. 112, para 108-188

a number of inpatient units in the United Kingdom and Switzerland with features and characteristics similar to the BAC.[18]

22. Professor McDermott said:

> We don't have evidence that the Barrett Adolescent Centre didn't do a fantastic job. … We don't have evidence either way.[19]
>
> …
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> I would just like to reiterate that there is no evidence at all that it [BAC] wasn't a place of very good care.[20]

23. As to the sub cohort of young people treated at the BAC, the submissions of Counsel Assisting at paragraphs 463 to 473 succinctly summarises the demographics of the group of young people and the reasons why the severity and acuity of a mental illness cannot necessarily be adequately captured in a specific diagnosis.

24. Dr Sadler undertook a review in late 2012 of the young people admitted to the BAC between 2007 and 2012. The review revealed that 98% of the BAC young people had disengaged from their educational networks for at least six months prior to admission, 90% had no face to face contact with peers, 83% had disengaged from community networks, 12% had been abandoned or removed by family networks and 35% had tenuous family networks.[21] Dr Sadler explained in evidence that some of the young people may have been managed and treated outside the BAC, if there had been appropriate and adequate accommodation and other step down facilities, which there were not.[22]

25. The suggestion that young people with psychosis are necessarily the most mentally unwell does not withstand scrutiny. This is demonstrated by the following exchange which occurred between Senior Counsel for WMHHS and Dr Stathis:

> And Dr Sadler gave some evidence yesterday – and I'm paraphrasing what he said – but, in effect, that you may have a young person with psychosis who's acutely unwell, but you might have someone who, for instance, has an anxiety disorder and is acutely unwell. Is the issue in terms of, perhaps, differentiation in treatment, that one is in more need of containment and, perhaps, restriction than the other?
>
> ---I mean, I guess it depends. We always need to look at mental health problems and consider the functional impairment and emotional distress inflicted on that young person by the mental health issue. So in considering treatment, you need to consider both those issues. You might have a young person with a psychotic illness which is causing relatively little functional impairment. You may have a young person with an anxiety

[18] Ex. 112, para 27-30
[19] Transcript of proceedings, Day 7, p. 7-65, ln 44-47
[20] Transcript of proceedings, Day 7, p. 7-67, ln 44-45
[21] Ex. 112, para 46
[22] Transcript of proceedings, Day 24, p. 24-6, ln 4-10

> disorder, and the disorder's causing significant functional impairment and emotional distress. And, of course, in terms of the patient's journey, that can vary from month to month. So it's quite complex.[23]

26. Nurses Sadler and Glupp have provided statements which contain criticisms of Dr Sadler and the treatment provided to the BAC young people. It is respectfully submitted that they are of no probative value. Neither nurse was called to give evidence. Further, parts of their statements are demonstrably incorrect. It is ludicrous to suggest Dr Sadler treated any of the young people by praying over them or laying his hands over them. Mr McGrath confirmed that Dr Sadler did not provide any such treatment.[24]

Anticipated closure of the BAC

27. On 2 November 2012, Ms Kelly informed Drs Sadler and Stedman that the MHAODB had decided to close the BAC. Consideration was being given to closing it by Christmas 2012. This information came as a surprise to Dr Sadler. He was understandably very concerned and the reasons for this are well summarised in paragraph 229 of his initial statement, which reads:

> I was also very concerned regarding the impact that the closure of BAC within such a short time frame would have on CYMHS services in the State and that additional services needed to be urgently developed within the community. For this reason I wrote to my child and adolescent psychiatrist colleagues as I was very anxious to ensure that the BAC adolescents could be adequately cared for once the centre closed. My concerns included a potential lack of an adequate knowledge base regarding adolescent mental health within the MHAODD Branch and the impact of the closure on acute inpatient beds in Brisbane, which I understood to be largely close to full occupancy. I was also concerned of how these services were going to be incorporated within the existing system. The treatment and management of these adolescents had been the subject of much consideration over the preceding 20 years with no alternative service to BAC having been identified. It was a very complex issue which was going to require a solution within an extremely short time frame. These concerns were in addition to my overriding concern of seeking to successfully treat longer stay adolescents with severe and complex mental health issues, within acute adolescent inpatient units.[25]

28. It was in the context of the abovementioned concerns, together with the fact that Dr Stedman considered closure within the short time frame of less than two months was achievable, that Dr Sadler reasonably and sensibly sought the input and support of his adolescent mental health colleagues in the emails he forwarded to them in early November 2013. The colleagues included directors of inpatient units and adolescent psychiatrists in community settings who were likely to be working in the receiving units where the BAC cohort would need to be transitioned to. The responses to Dr Sadler's emails confirm that Dr Sadler's colleagues shared his well-founded concerns.

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[23] Transcript of proceedings, Day 24, p. 24-63, ln 4-15
[24] Transcript of proceedings, Day 19, p. 19-16, ln 16-21
[25] Exhibit 112

Transition planning

29. WMHHS had not implemented policies or procedures to guide transition planning, management and implementation prior to Dr Sadler's [redacted]. However, it is common ground that transition planning in the context of the BAC cohort needed to commence as early as possible. Dr Brennan explained in her evidence that the commencement of transition varies enormously depending on the particular conditions but needs to be as early as possible and should occur over a period of some months.[26]

30. In paragraph 139 of his initial statement, Dr Sadler described his approach to transition as follows:

> From the time of admission, the objective was to transition BAC adolescents back into the community if possible. There was and could be no set time frame for this transition. Such a course needed to be considered in the context of the individual needs and the circumstance of each BAC adolescent.[27]

31. Dr Sadler expanded on this in his evidence, where he said:

> So transition was a process that occurred over quite a number of months. So we would be providing the opportunity for the young person to attend outside activities, perhaps connect with a school, perhaps spend longer periods of time at home, perhaps commence a work placement. So all of these were part of the transition process.[28]

32. In response to a question from Mr Mullins, Dr Sadler again addressed this issue in the following way:

> So transition as such is a – is what – we saw that as a – a process that began fairly early within the period of the – the young person's stay there. So once they are ready to complete and – and engage with the community we – we then began to link them up with those parts so that there wasn't a stage where you would – they would be in there full-time and then go into the community with – there would be multiple stages in which there would be linkages with the community and we tried to maintain linkages with family and linkages with referring services.[29]

33. The Case Planning Workshops held every two to three months provided a valuable opportunity to link the young people at the BAC with the referring agency, whether it was a private psychiatrist, private psychologist or clinicians from a CMHYS. The external agency would typically attend these workshops in person, by video conference or by teleconference when reviewing assessments, progress in recovery and goals. There was a collaborative approach with input from the BAC treating team, the adolescent and their family and the external agency.[30]

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[26] Transcript of proceedings, Day 20, p. 20-16, ln 19-41

[27] Exhibit 112

[28] Transcript of proceedings, Day 17, p. 17-24, ln 36-46

[29] Transcript of proceedings, Day 23, p. 23-63, ln 36-46

[30] Exhibit 112, para 34(e)

34. Further evidence in relation to the comprehensive approach to transition of the BAC young people can be found at paragraphs 142 and 143 of Dr Sadler's initial statement.[31]

35. The approach of Dr Sadler to transitioning post the announcement of the closure decision on 6 August 2013, is detailed in his statements.[32] This was undoubtedly a challenging time for Dr Sadler, the other BAC staff, the young people and their families. Dr Sadler adopts and relies on the submissions of Counsel Assisting at paragraphs 332 to 334, including the conclusion that there ought to be no criticism of his approach to transition over this period of time.

ECRG and Planning Group

36. Senior Counsel for WMHHS cross examined Dr Sadler seeking to effectively establish that he was the '*lone ranger*' in the ECRG, from the perspective that he did not agree with the other members in so far as limiting inpatient stay in a Tier 3 facility to six months. Dr Sadler considered it was reasonable to review young people in such a facility at the six month period but not to impose it as an arbitrary maximum length of stay. Dr Sadler's concerns with such an approach stemmed from his extensive experience in treating the young people at the BAC. Professor Martin shared Dr Sadler's concerns as evidenced from the following extract of his oral evidence:

> Thank you, Professor Martin. … You also talk in this paragraph that you consider that such long term inpatient care needs to be provided even if it is limited to the six months. So am I correct in understanding what you're saying in this paragraph, that you think it needs to be there? Are you saying it is to be limited, or is your evidence that it will really need to be reviewed at the six month point and at some time, depending on the young person, it may need to be extended?
>
> ….Look, I'm aware of the bureaucratic and financial imperative to limit services as much as you possibly can. So it's nice to be able to set these limits. But, from my perspective, they're silly because as I've already said when you're working in this area you are trying to do the job to enable the young person to live their lives sensibly, sanely, happily in the community, ultimately. And so you work with them for as long as it's going to take. Now, I think that if there is, let's say, an ongoing threat or worry of abuse in the family then you are seriously going to ask the question about whether you can have this young person going back into the family until you've got checks and balances or whatever that is to stop that process.
>
> …..The problems don't go away. If you haven't got a longer-term service of some sort then the young person is going to spend an awfully long time in your acute units and they're actually more expensive than a longer-term unit. So it – it worries me when we say no, no, we're not doing anything long-term, we're not going to do that. Well, okay, but these kids are still going to be troubled. They're still going to need admission. So either they're going to do, you know, a couple of months in an inpatient unit then go out, deteriorate – sorry – deteriorate and then come back into that inpatient unit in which case they could have stayed there and gone on with the work. I just think we must not be silly about this. We have to think it through and there are young people who are grossly distorted by the trauma and abuse that they've suffered and I think it does take them a

[31] Exhibit 112
[32] Exhibit 112, para 250-255; Exhibit 254, para 2-7

> number of years to actually get to the point where they feel comfortable to live in the real world and confident that they can withstand the slings and arrows of outrageous fortune.[33]

37. As to the Planning Group, Dr Sadler was a member of it and attended the May 2013 meeting via telephone from Townsville. It seems uncontroversial that at the meeting there was a discussion around whether wrap around services would be adequate in light of the ECRG recommendation for a Tier 3 service. Dr Sadler did not consider they would be and raised his concerns at the meeting and in a subsequent email to Dr Kingswell a few days later. It was his understanding that this issue remained unresolved at the conclusion of the May 2013 Planning Group meeting.[34] Dr Sadler was unaware at the time that there were to be no further Planning Group meetings.

Jennifer Rosengren
Counsel on behalf of Dr Sadler
23 March 2016

[33] Transcript of proceedings, Day 25, p. 25-29
[34] Transcript of proceedings, Day 23, p. 23-97, ln 5-40